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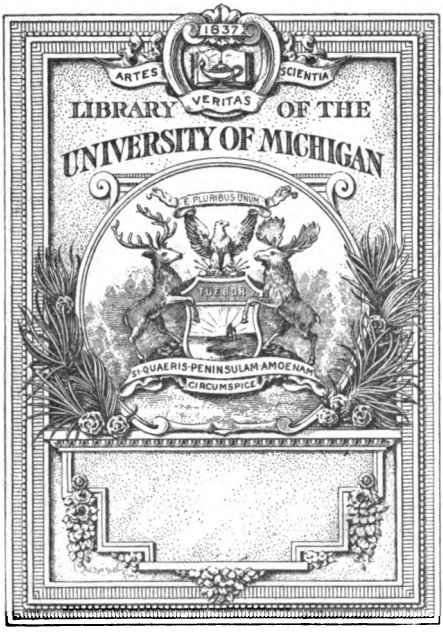

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Medical gazette

THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY.

A WEEKLY JOURNAL OF MEDICINE, SURGERY, AND THE COLLATERAL SCIENCES,

EDITED BY

EDWARD J.[o]hn BERMINGHAM, A. M., M. D., 1853

SURGEON TO THE GOOD SAMARITAN HOSPITAL FOR DISEASES OF THE RECTUM AND TO THE OUT-PATIENT DEPARTMENT OF BELLEVUE HOSPITAL, PHYSICIAN TO THE CHAPIN HOME, FELLOW OF THE NEW YORK ACADEMY OF MEDICINE, MEMBER OF THE MEDICAL SOCIETY OF THE COUNTY OF NEW YORK.

AND

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H.[a]Try H.[ubbe]ll KANE, M. D., Associate Editor. 1854

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LECTURES.

LECTURES ON PARALYSIS AND CONVULSIONS AS EFFECTS OF ORGANIC DISEASE OF THE BRAIN.

Delivered at Bellevue Hospital Medical College.

BY

C. E. BROWN-SEQUARD, M. D., ETC.

LECTURE IV.

GENTLEMEN:—In the last lecture, I attempted to give you facts that prove that a lesion on one side of the brain can produce the greatest variety of paralyses. You may perhaps think, therefore, that it is an extremely difficult matter to diagnosticate and to localize the lesion in brain disease. No doubt it is a most difficult matter, but I shall give you numerous facts which will enable you to do this with a certain degree of positiveness.

I had almost forgotten to mention a theory of Dr. Broadbent, of London, advanced to explain the difficulty in determining the seat of a lesion, which is the cause of paralysis. In most cases of hemiplegia

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from brain disease the paralysis is limited to the arm, leg, and face. There are many parts of the body that escape paralysis, and these parts are generally the muscles of the trunk and neck, and the connecting muscles of the limbs—that is, those muscles which are attached on one side of the trunk, and on the other to the limbs. In the immense majority of cases of hemiplegia these muscles are exempt from the paralysis that affects the other muscles. Now Dr. Broadbent said that certain parts of our system depend for their power of motion on a centre at the lower part of the pons Varolii, or the upper part of the medulla oblongata. He admits that one part of the corpus restiformis is alone sufficient to move two sides of the body, and, therefore, these muscles escape on both sides, when one side only is diseased. This theory is true in a measure, but otherwise it is false, because he considered this portion of the gray matter as a centre for these muscles. The reality is that one part of the brain is sufficient for the whole body.

Now, from these facts, I will pass on to the consideration of the significance of certain symptoms by which we are enabled to locate the seat of a lesion that causes paralysis.

There is one fact that it is very important to understand fully. You very well know that there are a number of nerves arising from the base of the brain that serve for the various special senses, for tactile sensibility, and for motion also. Now we must make a distinction between cases of paralysis that depend on a disease which strikes at the place from which the nerve comes, that is, a lesion that strikes at the trunk or roots of origin of a nerve, and those cases in which the lesion is beyond the point of entrance of these nerves in the base of the brain. Take, for instance, a cell in the medulla oblongata which is connected with a motor nerve fibre. Now a disease anywhere between the cell and the periphery of the medulla, or over the position of the cell, destroys the fibre of the nerve, and also the cells from which it arises. It is the same as if the nerve were destroyed beyond its point of exit. But suppose the disease is situated beyond these cells, in a portion from which there are no nerve fibres arising. Here there is something completely different—the nerve fibres or roots are untouched. In those cases of paralysis which depend on the destruction both of cells which give rise to nerve fibres and the fibres, or that depend on the destruction of the fibres themselves, or depend on the lesions that strike the cells themselves, there is something different from those cases in which the lesion strikes those cells that are beyond the cells from which the fibres arise. In all that I said in the last lecture of paralysis of the eye, tongue, face, etc., I had reference only to disease of cells which are in connection with those nerves that supply the parts spoken of. When you have a disease striking at a nerve or its root before its origin from the base of the brain, the paralysis occurs on the same side as the disease, and this fact is very evident, for it is the same thing as if you divided the nerve itself in any part of its course.

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In what I shall now have to say as regards the diagnosis and localization of cerebral disease, what I have said in reference to the difference that occurs when the disease is situated at a point where the cells give origin to the nerve fibres, or where it is located at a point beyond it, is of the very greatest importance.

For the sake of illustration, let us take a disease situated in the pons Varolii. In two cases, in one of which the disease is situated above the origin of the facial nerve, and in the other where the lesion is located at the root of the nerve, there will be a characteristic difference. In the second case, where the disease is on the root, or the cells of origin of the root of the nerve, the face will be affected on the same side as the lesion. In the former instance, if the disease is located elsewhere, beyond the cells of origin, the face will be affected on the opposite side.

Now as regards the limbs. As a rule, we find paralysis on the opposite side of the body from that on which the disease occurs. When a disease strikes the origin of a nerve the paralysis is on the same side. We find this true likewise in the case of all the nerves of the brain, whether or not they be nerves of motion. The olfactory, optic, or any other of them are similarly affected.

But to come now to the diagnosis of various cases of hemiplegia. We will first point out the differences that exist before coming to the points concerning particular locations. Disease of the upper part of the spinal cord, as well as of the brain itself, can produce hemiplegia. Take two individuals who are suddenly struck down with loss of consciousness and some trace of convulsions. After recovery from the first symptoms you find that there is paralysis in one-half of the body. Suppose it to be the right half of the body in both cases. One of these individuals makes a grimace on the opposite side of the face, and you might consider that the disease is on the same side. (This point has not been mentioned in any of the text-books, and has been noticed only by myself.) If you pay attention only to the paralysis on the left side of the face and the right side of the body, you will be led to believe that the lesion is situated in the brain. You might, however, be seriously mistaken, because a lesion of one-half of the spinal cord, near the medulla oblongata, can produce all of these symptoms.

In many cases the side that seems to be paralyzed is not really the paralyzed side. In fact there may be no paralysis at all. The appearance of paralysis may come from the fact that a spasmodic state of the muscles exists. In certain cases of spinal hemiplegia the disease is limited to one-half of the cord. In these cases you will find features that make this form of paralysis distinguishable from those cases of paralysis that are due to disease of the brain, putting aside only two or three cases that I know of. If you examine the patient carefully you will find, if the lesion be on the right side, paralysis of the two right limbs. There is no diminution of sensibility, but, on the contrary, a very considerable increase of sensibility, as measured by the æsthesiometer—the compasses of Weber, modified. Instead of

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only being able to detect the two points of the instrument at a distance of three lines from each other on the palm of the hand, which is the normal distance in that location, the patient may be able to appreciate the two distinct points when they are nearer to each other. This hyperæsthesia may be very great.

In the case of Charles Sumner, who was struck down on the floor of the Senate Chamber, the back part of the spine was injured. On the back part of the neck he could recognize the two distinct points when they were almost touching. In the spinal region, in the normal condition, the points of the instrument must be two inches apart in order to be recognized distinctly. There is, then, considerable hyperæsthesia; in other words, the normal sensibility is very much increased in spinal hemiplegia.

Besides the abnormal increase of the tactile sensibility, the sensation of pain is also much greater. In some cases a slight touch may be so painful as to cause the patient actually to scream. (There is likewise an increase in the power of detecting temperature, the patient, often, not being able to bear the contact of anything hot or cold, the pain produced is so great.) There is likewise increase of the power to recognize the sensation of tickling.

Another feature is that the muscular sense is not impaired. Indeed, when the patient recovers a little, he will know where the limb is, without first having to put his hand on it to feel.

On the side opposite to the disease there may be a great loss of sensibility.

As regards the temperature of the parts there is another important feature. The surface is very much warmer on that side on which the muscles are paralyzed. There is an increased temperature on the side of the paralysis and a diminished thermometric height on the opposite side. You will likewise find the face warmer on the side of the lesion. You get the same results as if the fibres of the sympathetic nerve are divided on that side of the cord. There will be great redness of the face, of the eye, and of the ear.

The pupil of the eye is also dilated on the same side. This effect follows galvanism of the sympathetic nerve of the head. The muscles are contracted simply because of the increased afflux of blood to the parts. The effects do not depend upon a changed condition of nervous centres, but upon a greater tonicity of the muscles, which results from their increased supply of blood: In localizing the lesion in these cases, besides this positive evidence, we have the fact that a great many other symptoms that are present when there is disease of the base of the brain do not exist.

In a case of disease of one-half of the spinal cord there is usually a feeling of stricture on one-half of the body at the level of the lesion in the cord. A lesion in the spinal cord, although it may destroy a great deal of tissue in its vicinity, only alters some of the sensitive roots in its neighborhood in such a way that hyperæsthesia is p ro-
ced. The body is thus separated into three zones—two of hyper-

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æsthesia and one of anæsthesia. There is nothing at all of this kind in disease of the base of the brain; so you see that the diagnosis can be made very easily in this way.

When the disease is situated in the medulla oblongata or pons Varolii, the general symptoms are extremely interesting. It is very necessary to be able to diognosticate clearly the exact seat of the lesion in such a case, for the prognosis depends altogether upon the diagnosis, and the means of treatment to be employed in all cases are not the same, but must vary according to the seat in the base of the brain. The chief point is this, that the nerves implicated show the locality in which the disease is situated. Suppose that the crus cerebri, pons Varolii, and medulla oblongata are destroyed; in other words, almost the whole of the base of the brain, behind the optic bands. You then find that all the nerves that take origin here are more or less implicated. If you know what these nerves are, you can readily understand the results that are produced. When the third pair are involved you find the effect in a change in the motor power of the eye. The ball cannot be moved upward, downward, or inward. The effects are very complex, but they are in harmony with what we know of the function of these nerves.

The paralysis, instead of being on the same side, is on the opposite side in the limbs, and the loss of sensation appears where the loss of motion exists. In disease of the spinal cord you will recollect that I said that there was no anæsthesia on the affected side, but, on the other hand, a hyperæsthetic condition. Here there is a loss of feeling on the same side as the loss of motion.

The urinary secretion is disturbed. It is increased immensely in amount, with or without the presence of sugar. You know there are two kinds of diabetes. Diabetes insipidus, which consists in the excretion of a very large quantity of urine, which, however, does not contain sugar, and a second variety, termed mellitic diabetes, in which the urine contains sugar. These two forms are very common in cases of disease of the whole base of the brain, and may exist in disease of any part of the brain, but are never present in disease of the spinal cord.

I showed in a previous lecture how a lesion of the pons Varolii or medulla affects the lungs, almost in every instance and at once, in animals, and likewise very frequently in man. One of the first effects of such a lesion is to produce a considerable congestion of the lungs. In disease of the pons Varolii, in that portion just where the crus cerebri enters it, we often have a hæmorrhage of the lungs, sometimes slight in amount, but often sufficient to cause death. This pulmonary hæmorrhage may occur in connection with a hæmorrhage at the base of the brain, and some have supposed both lesions to be due to the same cause.

Charcot and Bouchard discovered that cerebral hæmorrhage almost always occurs as the result of the rupture of an aneurism. Very frequently in persons past fifty years of age the walls of the arteries en-

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large, and as there is no thickening, but, on the contrary, a thinning, the walls break, and the hæmorrhage is almost invariably due to this cause. As it has been found that sometimes the veins of the lungs are in the same condition, it was thought that a hæmorrhage in those organs depended on the same causes, and was coincident. It is so perhaps sometimes, but when a hæmorrhage in the lungs follows quickly after a lesion in the brain, the latter is the cause of the former, perhaps by changing the circulation.

I have found that the pulmonary hæmorrhage depends on the following cause. Suppose the capillaries of the lungs are congested, contraction takes place in both the veins and arteries. The capillaries are then very much distended by the stagnant blood, they break, and you get the hæmorrhage. This is one of the frequent causes of death in disease of the pons Varolii, and it is a cause that has been altogether too insufficiently noticed, and, unfortunately, when people die from disease of the brain, the lungs are not properly examined. This is reprehensible, because many changes may take place in the lungs in consequence of brain disease, and they probably do in about one case out of every ten. First, there may be an active congestion, and then an inflammation. Foci of inflammation are frequently found in cases of disease of the brain. As the patient has always most difficulty and danger from his brain disease, the lesion in the lungs is overlooked, and proper local treatment is not applied. I have not the slightest doubt that a great many cases of death are due not to disease of the brain, but to subsequent disease in the lungs, which has passed entirely unnoticed.

Now another effect of very great interest can take place in disease of this portion of the base. The par vagum originates in the medulla oblongata. When the nerve is galvanized a stoppage in the heart's action is produced. The bearing of this fact is obvious. A lesion in this situation produces irritation of the par vagum and consequent diminution of the beating of the heart. This may be slight, or sufficient in itself to produce death. In many cases of disease of the bones in this neighborhood we have pressure on the par vagum which is sufficient to cause stoppage of the heart. The beating is diminished in force, but not in frequency, until finally the force of the contractions is lost entirely.

The œsophagus, pharynx, and larynx all receive their nervous filaments from the pneumogastric nerve, and when there is irritation in its origin there may be spasm of all these parts. In a case that I shall always remember, of a very dear friend of mine, there was intense spasm of the œosophagus. During the eight days that he survived from the commencement of his illness it was impossible to get anything whatever into his stomach—impossible even to introduce a tube, the spasm was so great. We injected pancreas and beef into the rectum, and in this way managed to nourish him during the time he lived. I may say, in passing, that this is the very best method of feeding a patient when we cannot get the food into the stomach. In

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the case I have mentioned life was prolonged for eight days without the slightest diminution in the weight of the body—without any wasting away or emaciation.

A disease pressing on the origin of the trigeminal nerves may be very easily diagnosticated by the changes produced in the state of the cornea. This membrane becomes inflamed, and, after a time, ulcerated. Magendie showed long ago that when the fifth pair was divided an alteration of nutrition was produced and the cornea entirely destroyed in a short time. He demonstrated also that all the senses were impaired, and he concluded that this nerve was concerned in all the special senses. He never would have drawn this conclusion if he had known the difference between loss of function produced by irritation and loss of function caused in a direct way. The nutrition of the organs of special sense is altered by an injury to the trigeminal nerve, and this fact is borne out by an abundance of other facts. A blow on the frontal nerve, or on another branch of the fifth nerve, may produce a total loss of sight. We do not conclude that it is therefore the nerve of sight. This result must take place through a reflex action, an irritation starting back from the seat of injury, and propagated again to the blood-vessels, thus materially altering the nutrition.

A disease in the optic thalamus, a part of the brain far removed from the origin of the trigeminus, can produce the same effect as division of the nerve itself. There is, therefore, nothing essentially belonging in a direct way to the trigeminal nerve, as regards vision, when it is diseased.

When there is a loss of feeling in the face on one side, and a loss of the senses, and of the cornea on the same side, the lesion that produces them is on the same side of the brain.

Some ten years ago a patient consulted me, in Boston, who had paralysis of the limbs on one side of the body, with paralysis on the same side of the face, and I concluded that the lesion was situated in the pons Varolii on the same side. A short time afterwards he died, and at the autopsy the lesion was found in the spot indicated. The diagnosis was made from a consideration of the symptoms that appeared in the face. A disease in the pons Varolii may produce paralysis on the same or on the opposite side of the body, together with symptoms in the face on the same side as the lesion. Thus you see we are enabled to localize the lesion, and it does not always cause alternate paralysis.

You may also have a lesion in that part of the brain at the origin of the trigeminus without paralysis of the limbs. In such a case you might think that the trigeminal nerve alone was affected, that the lesion was limited entirely to it, but this is not necessarily the case, as a great part of the pons Varolii may be destroyed without any paralysis, except of the nerves arising there. In a case reported by Prof. Stanley, of St. Bartholomew's Hospital, London, there was a very extensive lesion of the pons Varolii and paralysis on the same side of the face only, and the eye was destroyed.

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Another feature that we find present in cases of disease of the brain is, that instead of anæsthesia, you may have hyperæsthesia in the paralized limbs.

Sometimes you will find a remarkable absence of symptoms. Convulsions may be produced by irritation of the pons in animals, but it is not so in man. You get convulsions with least frequency in disease of this part of the brain.

Near the pons Varolii there is a portion of the brain that connects it with the cerebellum, called the crus cerebelli. Disease in this part may produce a rotatory movement round the main axis of the body, or cause progression in a circle. However, such a movement is not specially limited to disease of this part, as a lesion in other parts may cause it as well.

If we now ascend and place our attention on the crus cerebri, the diagnosis of a case of hemiplegia depends on the facts that follow. The paralysis, as I have so frequently observed, may appear on the same or on the opposite side of the body, usually, however, on the opposite side. There are two well authenticated cases reported, that I know of, where it appeared on the same side. The crus cerebri has been considered as the only bond of union between the will power and the conductors in the production of voluntary motion and the perception of sensation. You should have, consequently, in disease of this part, anæsthesia and paralysis on the opposite side of the body. But this is absolutely false. Thirteen cases of disease limited to this part of the brain have been pretty well studied, in which no such facts were seen. Cases of complete paralysis are few, and of complete anæsthesia are very rare indeed. So little is the old view true in these cases that there are ten in number of them in which there was no paralysis at all, though the whole mass of the crus was destroyed. These are extremely clear cases, that show that one crus is sufficient for the transmission of voluntary motion and sensibility.

I have said that in these cases paralysis seemed not to exist at all. It is possible that in the future there may be other means employed to discover paralysis. If a man can walk and stand, and can grasp firmly, you are inclined to think that there is no paralysis. I have frequently said, in the course of my remarks, that in many cases of disease in certain portions of the brain there is no paralysis. I must say, however, that it is my belief that, if we studied these cases more carefully, we should find paralysis more or less marked.

I here show you an instrument, invented by a friend of mine, which enables us to detect paralysis more accurately in parts that we could not determine the power of so well before its introduction. It consists of two bars fastened on each end to a leg, and the legs coming from each side cross each other in the same manner as the legs of a saw-buck. At the intersection on each side is a spring with a scale and an index. By approximation of the two bars we get a measure of the force of the muscles employed in pressing them together. By this instrument we can measure the strength of the foot by placing it

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on the floor and pressing the uppermost side. In the same way the power of the muscles of the leg may be determined. Also, if we place it in the bend of the knee and make the patient bend his leg backwards, we can ascertain the strength of these muscles. In this way we can find if there be any loss of power, or if there be any difference between the two sides. So it may be applied to the bend of the elbow, the axilla, the hand, and other parts of the body. This instrument shows the relative strength of the two limbs, or of analogous parts on the two sides, in a very perfect manner, and was invented by a friend of mine, who is now dead. Almost any part of the body may be thus tested by its means.

If we do not measure the force of the muscles of a patient suffering from brain disease with great care we cannot tell accurately the degree of paralysis that is present. Therefore, when I say that there are cases of marked destruction of the crus cerebri, or of any other part of the brain, without paralysis, I simply mean that paralysis has not been recognized and recorded. But I believe that there is always some paralysis, which we have not as yet adequate means of determining.

CLINICAL LECTURE.

Delivered in the Hospital of the University of Pennsylvania.

BY

HORATIO C. WOOD, Jr., M. D.,

Professor of Materia Medica and Therapeutics and Clinical Professor of Nervous Diseases in the University of Pennsylvania.

I. Multiple Sclerosis. II. Writer's Palsy.

Multiple Sclerosis.—Sclerosis is a chronic imflammation of the neuroglia. Multiple sclerosis occurs in little spots, or nodules, and may affect the brain alone, or the spinal cord alone, or both brain and cord. There are consequently three forms of multiple sclerosis, cerebral, spinal, and cerebro-spinal. Multiple cerebral sclerosis is comparatively rare, and its symptoms very obscure. It usually begins with severe, irregular pains in the head; paralysis and tremors, with epileptiform attacks and marked mental deterioration, failure of memory, etc. The most common symptoms are loss of power with tremors. The severer symptoms are only marked in rare cases. In multiple cerebro-spinal sclerosis, the tremors are at first only excited by voluntary movement, but finally they become persistent. Where the spine only is affected, according to some authorities, there are no tremors. Where the brain only is affected, the tremors are constant. In all three forms there is always palsy; incomplete, at first, but gradually producing entire loss of power. In the spinal form, the palsy is the main symptom. In many cases there are periodic convulsive movements of the limbs. In multiple spinal sclerosis, the symptoms become more and more severe, finally bringing on tonic

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contraction of the muscles of the hands and legs. These cases, though exceedingly obscure, will very frequently come under your notice. Multiple spinal sclerosis, I will add, may affect either the anterior, or posterior columns of the cord. I am able to present to your notice, to-day, two cases illustrating two of the different forms of sclerosis.

CASE I.—R. Mc., born in Ireland, dates the beginning of his disease back to 1875, when he overstrained his wrist in piling bricks. Immediately after that time, the part began to tremble, and in one year the whole limb was involved. He was admitted to the hospital last March. A few months ago the tremors extended to his whole body. These tremors are constant, and are very much aggravated by any excitement, or the least physical exertion. In this case there was palsy of the right arm before the appearance of the tremors. This order, however, is very frequently reversed. The patient usually has a bad headache when he gets up in the morning, and is very easily fatigued. There is no failure of memory, as yet, and his eyesight is not affected. In some cases there is constant twitching of the eyelids. I cannot say positively whether or not this man has tremors while asleep. He has no difficulty in walking up and down stairs; can go down stairs without the assistance of the banister. There is no *festination* in this case.

CASE II.—A sailor, of middle age, German by birth. Has had syphilis and gonorrhœa frequently. The tremors in this man are only excited by physical exertion, such as walking, etc. The patient has no headache and no pain. In neither of these cases has there been at any time trouble with the bladder. This man has festination very markedly. He says he feels as if some one were constantly pushing him forward as he walks; he has a continual, irresistible tendency to go forward until he gets into a regular run. He can go up stairs alone, but in going down stairs he has to take hold of the banisters to keep himself from falling.

Case I is an example of multiple cerebral scleroses in which the tremors are constant. *Case II* is one of multiple cerebro-spinal sclerosis. The last case presents some of the symptoms of locomotor ataxia, but it is not an instance of that disease.

The etiology of the multiple scleroses is exceedingly obscure. In some instances they have been brought on by exposure to wet and cold. Thus in *Case II* we are given to understand that the man first noticed the tremors one very rough day at sea, when he was in the rigging. In many reported cases the inception of the disorder dated back to some mental strain or overwork. I have never heard of a case of paralysis agitans produced by syphilis. It is easy to see, however, how it might have such a cause. [The paralysis agitans of Dr. Hammond is not what is generally understood by this name, but is a form of local chorea.]

As regards treatment, very little can be done in the severer forms, as in *Case I.* In fact, nothing can be done in true cases of the affec-

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tion. Dr. Hammond claims some good results from the administration of fifteen drops of the chloride of barium thrice daily. He also advises the use of the tincture of hyoscyamus; but neither of these remedies have had any effect whatsoever in my hands. The galvanic current may be employed, but usually fails utterly to produce any good.

WRITER'S PALSY.

The patient is a book-keeper by profession, and has been in the habit of writing twelve hours a day for four days in the week. The first warning of the palsy occurred about six months ago. His hand would get tired easily when writing; there was no pain in the arm at first, but a very marked cramp in the wrist and difficulty in bringing the fingers together to hold the pen. The thumb could not be put against the forefinger. The man has not lost his power of grasp at all, except, perhaps, in the right index finger.

Writer's cramp is a disease affecting book-keepers, merchants, and savants; in fact, all those who write excessively. The disease has two forms—the spasmodic and the paralytic. In the spasmodic variety the spasm may be either clonic or tonic. Most of the cases which come under our notice are paralytic. When there is spasm the pen is grasped so firmly that the writer finds difficulty in freeing his fingers. Writer's cramp, though common in men, is comparatively rare in women. The reasons for this are plain, since men do much more writing than women as a general thing. In the paralytic form there is usually pain in the hand and shooting pains in the arm.

What are the causes and pathology of writer's cramp? All of you know how difficult it is for the child to learn to write. This shows that the movements of writing are very delicate, and require an excessive amount of coordination. The chief muscles concerned in writing are the flexors of the thumb and index finger, and the flexors of the hand. In the process of writing these muscles execute an immense number of very delicate muscular contractions. All these facts necessitate an infinite strain upon the coordinating apparatus. When a child is learning to write, it is learning to train its coordinating apparatus. The will power, in writing, runs over certain paths of coordination. Usually those paths are open and easy. The cerebral centers, the paths of coordination, the muscular sense, and the motor tracts are all concerned in the act of writing.

Where is the palsy located in the paralytic form? It is originally in the paths of coordination. Through overuse some of these paths are injured, and so rendered no longer permeable to the will power. Thus there is a partial palsy. In the spasmodic form some of the paths are blocked up and some are not, and those which are blocked up receive more impulse than they can bear, and spasm is produced. In some cases there is disorder of the muscular sense, no doubt—the centres persist in sending out too strong an impulse, the muscular sense being vitiated, and so spasm occurs. There is some loss of muscular sense in the case of this patient.

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As regards treatment, the first thing to be done is to stop all the patient's writing at once, and enjoin absolute rest for the arm, and so for the coordinating apparatus. Rest is the main part of the treatment. Even with complete rest, the prognosis is unfavorable when the disease has gone on far. A little overuse, indeed, will at any time bring on all the trouble anew.

Medicinal treatment is twofold—(1) prophylactic, and (2) direct. Under the first head comes complete rest so far as possible. If the patient relies entirely for support upon his writing he may obtain rest by making use of a printing machine. It is always best for those liable to have writer's palsy to write with a broad-pointed pen. Quill pens are less likely to cause cramp than steel pens. When writing with a sharp pen and making delicate lines, coordination is, of course, more difficult. A thick, blunt pencil is very safe for those threatened with cramp. Some relief may be had by using a thick pen-holder. In cases of this kind, it has been recommended that all writing be done with a ball fastened to the pen-holder and held in the hollow of the hand. This does away with all delicate movements of coordination and relegates all motion to the wrist. The ball is very useful where only the fingers are affected.

If the system has run down tonics are indicated. They have, however, but slight effect upon the disease. Some have recommended the use of the constant current with the positive pole at the nape of the neck and a sponge in the palm; but I have never seen much good come of it. So, too, with manipulation and hypodermic injections of strychnia in the paralytic form; they are of but little value.

The best treatment is total abstinence from writing. If the patient attempt to force the movements of writing the whole body may be affected, causing loss of all coordinating power and a general breaking down of the nervous centres.

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ORIGINAL ARTICLES.

A HITHERTO UNRECOGNIZED SYMPTOM OF ISCHIATIC DISLOCATION OF THE HEAD OF THE FEMUR.

BY
W. W. DAWSON, M. D.,
Prof. Surgery Medical College of Ohio, Surgeon to Good Samaritan Hospital, Cincinnati, O.

Most writers describe the symptoms of dislocation into the ischiatic notch as differing from those of the iliac in degree alone, there being in the former less shortening, less inversion, less adduction, less flexion. Syme, some years ago, called attention to the arched position of the spine, when, the patient being recumbent, the dislocated limb is pressed upon a flat surface. He insists that this is characteristic, that there is no injury of the hip joint, "whether fracture, dislocation, or bruise," which gives this sign. In this he is certainly mistaken, it is often, if not always seen, when the head of the bone is upon the dorsum ilii. It is always present in the second stage of morbus coxarius.

Dr. Squires, of Elmira, New York, suggested a much more reliable means of diagnosis, when he called attention to the fact that, in *ancient* dislocations backward, the head of the bone may be detected in the notch by inserting the finger into the rectum or vagina. I have found this to be true in *recent* as well as in old cases.

There is in the ischiatic dislocation, when the limb is extended, but little, very little shortening. The head of the bone is thrown backward but usually very little upward—the ischiatic notch is upon an exact plane with the acetabulum, hence much shortening is impossible. For want of reflection upon this point, physicians have often been led into serious error and into most annoying lawsuits. Instances have occurred where cases have been left as reduced, from the fact, that when extended, both limbs were of equal length. A case of this kind came under my observation, in which much trouble originated from a mistake of this character; the limbs when extended were of equal length, yet the head of the femur was in the sciatic notch and was allowed to remain there.

Some years ago, I observed that when the position of the dislocated limb to the body is changed, a marked difference occurs in its relative length. *If the patient be placed upon his back and the thigh be flexed upon the trunk at a right angle, then the knee of the dislocated limb will sink below that of the other side from one to two inches.* A moment's reflection will make this clear. The ischiatic notch is situated directly behind the acetabulum, the head being thrown from one to to the other, the limb is shortened the distance from the centre of the

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cavity to the centre of the notch. This, in all cases, will be as much as one, it may be two or more inches.

Our great master in surgery, Gross, doubtless errs, when, in giving the symptoms of the ischiatic dislocation, he describes the head of the femur as situated "behind and *below* the acetabulum." If the head of the bone be below the acetabulum, then the limb should be lengthened, instead of, as he says, "shortened from a half to an inch."

Frank Hamilton says, "the position of the limb is, in some cases, nearly the same as in certain dislocations upon the dorsum. It is shortened usually about half an inch, the thigh being flexed upon the body, adducted, and rotated inwards; but the flexion is often less than in dislocations upon the dorsum, while on the other hand it is sometimes much greater."

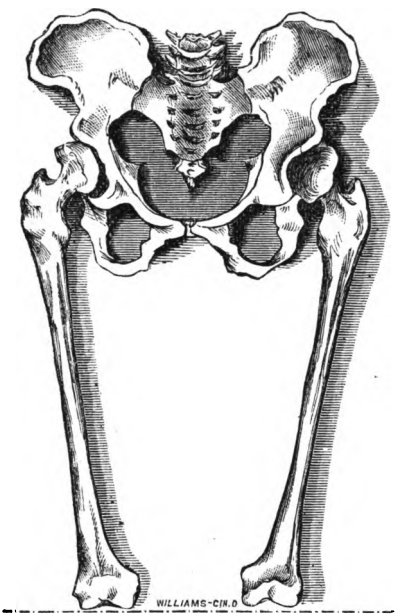

PLATE No. I.

Bigelow, in his learned work on the hip, scarcely recognizes the individuality of the ischiatic dislocation, he affirms that "the dislocation hitherto distinguished as 'upon the ischiatic notch,' and unnecessarily associated with it, is characterized by Sir Astley Cooper as differing from the dorsal displacement chiefly in producing less shortening of the limb." He looks upon the symptoms as differing only in degree.

Ashhurst groups the two together after this wise: "The symptoms

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of these forms of dislocation are usually well marked. There is shortening of the affected limb, varying from about half an inch in the dislocation below the tendon to one, two, or even three inches, in that on the dorsum ilii." He speaks of the inversion as being most marked in the dorsal; so also is there but slight difference in the axis of the limb in the dorsal; it "crosses the lower third" in the ischiatic "just above the knee."

Gant states the case thus: "Dislocation in the great sciatic notch presents similar signs, but in a lesser degree, thus rendering the characteristic appearances less marked."

Bryant upon this subject says: "Dislocation backward on the ischiatic notch forms about a seventh of all cases, and may be regarded as a variety of the one just described, indeed Erichsen describes the two forms together as the ilio-sciatic. It is characterized by the same but less marked symptoms."

Erichsen. "When the head of the bone slips a little farther back, so as to become lodged in the *sciatic notch*, we have the dislocation backwards of Sir Astley Cooper, or as Bigelow calls it, 'dorsal below the tendon,' because the head of the bone lies below the tendon of the obturator internus muscle. In this the same symptoms exist, though to a less degree, hence the diagnosis is proportionately difficult."

Gross says: "This dislocation in its symptoms bears so close a resemblance to the iliac that some writers are disposed to regard them merely as modifications of the same lesion, the one being an exaggerated form of the other. I have myself, however, always looked upon them as separate and distinct varieties. * * * The characteristic signs of the dislocation are, the situation of the head of the bone behind and below the acetabulum, a short distance above the tuberosity of the ischium; the comparatively slight shortening of the limb, the firm impaction of the thigh in its new locality, and the unusual distance between the trochanter and the spine of the illium."

Spence, in his Lectures upon Surgery, gives the backward dislocation this status: "The symptoms of dislocation into the ischiatic notch are somewhat similar to those attending the dislocation on the dorsum ilii." He disposes of Syme's arched spine test by the following terse statement: "If we bring the limb down, as we can do with force, we make the back arch; and if we lay the back flat the limb rises again. In the dislocation on the dorsum of the ilium this is one of the best diagnostics we can have. It is due to the angle at which the bone is fixed. Some speak as if this symptom were only referable to the dislocation into the ischiatic notch; but it is really less marked in that than in the other luxation." By "some" above, he evidently refers to his countryman, James Syme. Syme's test was received, as he urged it, by the profession as applicable to the ischiatic dislocation alone; but a single trial will show that Spence is right when he says that it is by no means peculiar to the dislocation into the notch.

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Carsten Halthouse, that acute observer and graphic writer, regards this dislocation "merely a variety of the former" (on the dorsum.) He finds that the shortening "rarely exceeds half an inch; adducion, inversion and flexion less."

Robert Allen, (Edinburgh, 1819,) looks upon this dislocation as rare. His signs are, "the limb is a little shortened, the foot and toes are turned inwards, the knee is a little bent, the trochanter major is placed further back than its natural situation, although turned toward the acetabulum, and if the patient is of spare habit, the head of the bone can be felt lodged in the sacro-ischiatic notch—more especially upon bending the thigh, which can be done to a certain extent."

Benjamin Bell, in his System of Surgery, 1799, teaches four dislocations of the hip: "Upward and backward, upward and forward,

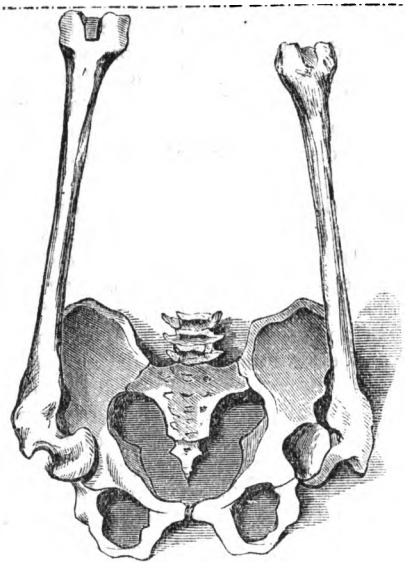

PLATE NO. II.

downward and backward, downward and forward, or directly downward. The first and third of these have very seldom been met with; and the most common variety, and the only one I have seen, is that in which the bone is thrown downward and forward, and lodged in the foramen ovale." The experience of surgeons differs widely from the assertion that the thyroid is the "most common variety." From his classification it is apparent that he did not recognize the lodgment of the head upon the sciatic notch as a possibility.

Dorsey, never having seen a sciatic dislocation, quotes from Boyer,

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who describes the head as lodging "at the junction of the os ilium and ischium," below the notch.

Boyer suspects the surgeons of his day of mistaking fractures of the neck for dislocations. The means of diagnosis have certainly improved, for few such mistakes are now made. "As has been well remarked by Sir Astley Cooper, the sciatic notch being situated higher than the acetabulum, (?) this luxation is in reality a luxation backward and upward, and not backward and downward, as it used to be described before his time. The limb, accordingly, is always shortened, sometimes to the extent of an inch, and sometimes only to a trifling extent; and it requires great care sometimes to ascertain that any difference of length exists between the two limbs, the injured limb often seeming to be of the same length of its fellow." The above quotation is from Costello's Cyclopedia of Surgery. The article was written by Maisonneuve. The lesson which the distinguished Frenchman teaches as coming from the great English surgeon upon the nearly equal length of the injured and the uninjured limbs when both are extended, and which is of so much practical value as an element of diagnosis, has doubtless been lost sight of by many writers and teachers who have followed.

Lizars makes the remarkable mistake of asserting that there is *a little more shortening in the sciatic than in the iliac.* The following statement is from page 177, vol. ii, of his System of Practical Surgery: "In this," (when the head is forced on the great sacro-ischiatic notch,) "there is a little more shortening and inversion of the limb, the great toe resting on the tarsus of the sound foot."

Petit doubts the sciatic as a primary dislocation; he is disposed to think that it is always secondary, the result of manipulation, the dorsal iliac being converted into the sciatic by the force executed by the reducing surgeon.

I have thus given extracts to show that up to this time no author, so far as I have read, has called attention to the difference in the length of the disturbed limb when extended and when flexed at a right angle with the pelvis. The extracts also show that the earlier writers had very vague ideas upon dislocations of the hip.

A reference to the plates, but more especially a trial with the skeleton, will make this matter patent to any one. As an element in diagnosis, in both plain and obscure cases, I think it will be of value.

Plate No. 1 shows the position when the limbs are extended; the shortening is slight—very slight—because, as I have said before, the notch is directly behind and upon the same plane with the acetabulum.

Plate No. 2 shows the limbs raised to a right angle with the recumbent trunk. The shortening, as will be seen, is very striking. It must be the difference between the centre of the acetabulum and the centre of the notch. This distance will be rarely less than two inches—often even more.

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HOSPITAL RECORDS.

BELLEVUE HOSPITAL, NEW YORK.

COMPOUND COMMINUTED FRACTURE OF LOWER JAW.

James Smith, aged 38,—married,—born in Germany. Admitted October 14th, 1877. Fell down from one of the bridges that cross the track at Grand Central Depot. Examination shows an oblique fracture of the lower jaw, at the right side, just at the angle. Another fracture exists at the right of the symphysis, the latter is comminuted. There is an incised wound on the chin, just below the lip, and another lower down along the margin of the bone. From the latter wound a piece of bone was taken out about an inch long and a quarter inch wide, which included the symphysis.

A closer examination, however, shows but one fracture, that on the right side extending obliquely downwards, from a point a little external to the symphysis. The wound beneath the chin and along the jaw is found to connect with the mouth anterior to the tongue, from this the saliva dribbles in considerable quantity. Two teeth were also knocked out. The whole is dressed with lightly applied carbolized dressings. The wounds washed out twice each day with carbolized water.

October 17th.—The fragments are kept in a fair position by means of pads over each angle, and a four-tailed bandage at fracture, near symphysis. On account of fracture at angle, the fragments over-rode each other to the extent of about one-half inch, and there was an upward displacement to about the same extent.

October 20th.—Put the jaw in plaster of Paris, after having gotten the fragments in very fair position. A fenestra was cut communicating with the wound opening into the mouth. Mouth very foul from decomposed articles of food.

October 22d.—The bandages failed to keep the jaw in good position; were removed. Fracture reduced, and a new bandage applied. Immediately after the application, patient said he thought the fragments had again slipped.

October 24th.—The last apparatus removed; not affecting the desired result.

October 25th.—A plaster of Paris cap placed over head. This gave a firm support to two bands placed under and around the chin. The bands were made of webbing, and had buckles attached so as to allow of tightening or loosing, according to circumstances as required. An inter-dental gutta-percha splint placed over teeth of lower jaw. This apparatus succeeds better than any that has yet been tried, and holds the jaw in a very fair position.

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October 27th.—New inter-dental splint applied, and this together with changing position of bands around chin, keeps jaw in even better position than it was before.

November 13th.—Went out yesterday on pass, and at 9 this A. M., came in very drunk. Head-piece disarranged and inter-dental splint partially out of place. Sent to cells.

November 23th.—Several small pieces of diseased bone have come away from jaw since last entry, and denuded portions can be felt with probe through the wound underneath the jaw. The latter has very nearly closed. Slight amount of discharge still continuing.

November 28th.—Apparatus removed. Fragments firmly united with perfect position.

FRACTURE OF INF. MAXILLA.

Catherine Stimson,—aged 35,—born in United States,—widow. Admitted October 23d. On Sunday before admission was knocked down and kicked in the face by an unknown man. Examination shows first, fracture just to right of symphysis, and second, another fracture at the angle on left side. The face was somewhat swollen, and there were ecchymotic spots under the eyes and on the lower lip.

October 24th.—Jaws confined in a Barton's bandage, but so modified that a firm support was given on the top of the head by making a species of plaster cap. From this latter as a support two bands were passed, one around and one beneath the jaw. Apparatus succeeds admirably and keeps the fragments in almost perfect apposition.

November 14th.—An abscess appearing on the left side anterior to line of strap that holds jaw in position.

November 18th.—Has suffered a good deal of pain since last entry. Explored with a hypodermic needle, but found no pus. Ordered poultice to cheek.

November 19th.—Much relieved.

November 23d.—The fracture on right side has united quite firmly, but there is still some motion in one on left side.

November 30th.—Apparatus removed and everything perfectly united without any deformity.

The apparatus applied in these cases is a novel one, and offers many advantages over any that has hitherto been used. The plaster cap over the head may be made light by cutting out portions of the crown and at the same time give a fixed and permanent support to the bands that hold the fragments in apposition. The webbing bands are firmly incorporated with the cap by placing them between the folds of the plaster bandages. To these straps, buckles are fastened and thus we have an admirable means of regulating the support given to the fragments without the trouble of applying new dressings. The excellent results obtained in the two cases related, are abundant evidence of the utility and ease of adjustment of this method of dressing.

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LONG ISLAND COLLEGE HOSPITAL, BROOKLYN.

Reported by E. J. McPHARLIN, M. D., Resident Surgeon.

DEATH FROM ENTRANCE OF AIR INTO THE VEINS IN A CASE OF COMPOUND FRACTURE.

Jas. McNally, aet. 33, car-driver, was admitted to Long Island College Hospital, service of Dr. J. H. Hobart Burge, Nov. 8, 1877.

In attempting to jump off the front platform of his car, he was struck on the left side by a dummy engine in motion; thrown about fifteen feet and sustained a fracture of the right femur in the upper third; also contused wounds of the head and face. When admitted, an hour after the accident, he was suffering greatly from shock, but soon revived under stimulus. A wound on the left cheek extended up under the conjunctiva of the corresponding eye. This was sewn up before the patient was admitted, by a surgeon who stated that he had examined it carefully and that it was simply a contused wound.

November 10th, 7 P. M.—The patient up to this time was quite easy, and only complained of a little soreness about the head. Then developed a slight delirium, which continued about four hours, when suddenly, he began to breathe stertorously, and died almost immediately.

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POST MORTEM.—The wound on the left cheek led down to a comminuted fracture of the ethmoid, making it compound. Foreign particles, that appeared to be pieces of a felt hat, were wedged in between the fragments of bone and pressed on the base of the cerebrum, where there was evidence of a suppurative meningitis.

Air was found in the heart, liver, spleen, and great vessels. The presence of air in these parts could not be accounted for otherwise than by its entrance into the venous channels of the brain at the place of fracture.

Every surgeon is familiar with the fact that in a few instances death has occurred very suddenly in consequence of the entrance of air into the circulation during large surgical operations. I do not remember to have seen any record of a similar cause of death after accident, and have therefore thought this case worthy of notice.

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PERISCOPE.

COLLABORATORS.

Dermatology.—HENRY G. PIFFARD, M. D., Professor of Dermatology in the University of New York.
Diseases of the Nervous System.—EDWARD C. SEGUIN, M. D., Professor of Diseases of the Nervous System in the College of Physicians and Surgeons, New York.
Diseases of Women and Children.—FRANK P. FOSTER, M. D., Gynecologist to the Out-Patient Department, New York Hospital.
General Surgery.—EDWARD J. BERMINGHAM, M. D., Surgeon to the Good Samaritan Hospital for Diseases of the Rectum, and to the Out-Patient Department, Bellevue Hospital, New York.
Genito-Urinary Diseases and Syphilis.—ROBERT W. TAYLOR, M. D., Professor of Dermatology in the University of Vermont.
Ophthalmology and Otology.—S. B. ST. JOHN, M. D., Assistant Surgeon to the New York Eye and Ear Infirmary.
Orthopedic Surgery.—NEWTON M. SHAFFER, M. D., Surgeon to the New York Orthopedic Dispensary and Hospital.
Practical Medicine.—E. DARWIN HUDSON, JR., M. D., Professor of Practice of Medicine, Woman's Medical College, New York.

ETIOLOGY OF PROGRESSIVE MYOPIA.

A VALUABLE paper by Dr. E. G. Loring, of New York, extracted from the Trans. of the Int. Med. Congress at Philadelphia, 1876, shows plainly that the development of this frequent and serious disease is not so much due, as has been widely supposed, to hereditary tendency, although this is undoubtedly an important factor. A laborious and exhaustive research into European and American statistics, (many of the latter collected by the author,) and a comparison of the amount of myopia with the degree of ocular work, shows that close application of the eyes to fine work during the early years of life accounts for a large amount of the myopia in civilized communities.

Tables are given representing schematically the percentage of myopia in Russian, German and American schools, and in the Russian table we find the percentage rising steadily from 15 per cent. in the lowest class to 42.8-10 per cent. in the highest. In the German it rises from 12 per cent. to 62 per cent., and in the American from 3 per cent. to 26.7 per cent. These results correspond very nearly to the amount of work done with the eyes of the school children of the three countries.

The prolonged tension of the accommodation during study, including the associated action of the recti muscles, is considered as a potent factor in the process, the influence of the ciliary muscle alone being held as of comparatively little importance.

Dr. Loring, in a paper on the same subject, read before the County Medical Society, laid emphasis on the fact that we do not find an unusual amount of myopia among type-setters and others who do fine work, but who do not begin to learn their work until the formative period of life is nearly ended.

In the proceedings of the Congrés Périodique International des Sciences Medicales, M. Hattenhoff reported as follows:

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(1.) The ordinary causes of myopia are heredity and ocular work, combined or singly.

(2.) Hypermetropia can be changed into myopia by ocular work.

(3.) The progress of civilization, and especially of education, tends to increase the amount of myopia.

(4.) The predisposition to acquired myopia is often hereditary.

(5.) In ocular work three factors are principally concerned in producing myopia—accommodation, convergence of visual axes, and oculo-cephalic congestion.

(6.) The conditions of age, circumstances, duration of work, nature of objects viewed, and state of visual apparatus powerfully influence the development of myopia.

(7.) The prophylaxis of myopia includes individual hygienic measures at school and at home, which are in great part realizable by the united efforts of physicians and authorities. Among these measures may be reckoned the use of convex glasses for hypermetropes.

S. B. St. J.

THE PLASTER OF PARIS JACKET IN SPINAL DISEASES,

BY

EDMUND ANDREWS, A. M., M. D. (*The Chicago Medical Journal and Examiner*, December, 1877.)

After describing the indication for support in Pott's disease, and the methods by which "curative apparatus" acts, the author compares the advantages with the disadvantages of the plaster jacket; his conclusions being as follows: "From these considerations it is evident that the plaster of Paris jacket is a very valuable appliance in numerous cases, and has the especial merit of being an extempore apparatus which can be applied, however remote the patient may be from instrument makers, and however impoverished he may be in purse. It has, however, some special disadvantages, and at its best is in no way superior to a well-fitted combination brace, containing the corset and splint in one instrument. Indeed, the superior convenience and tidiness of the combination brace will always cause it to be preferred by a large portion of surgeons and patients." N. M. S.

IODIC PURPURA,

BY

Fournier. (*Lyon Medical*, October 28.)

Fournier describes an eruption following the use of the iodide of potassium. He has seen fifteen cases. The eruption has a special seat, being confined to the leg, between the ankle and the knee, and always more fully developed on the anterior aspect of the limb. The spots vary in size from a pin's head to a millet seed. Their form is round or oval, without any perceptible elevation. They are unac-

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companied with pain or itching, and usually escape the attention of the patient. These macules were not developed under massive, but under moderate doses of one to two grams. In certain cases Fournier continued the iodic medication, and found that spots gradually faded away; but if the dose were increased, they reappeared. [The influence of iodide of potassium in the production of cutaneous lesions was first noted, we believe, by the late Dr. John O'Reilly, of this city. (*N. Y. Med. Gaz.*, Jan., 1854.) Beside other lesions, the doctor specially refers to a form of iodic purpura.] H. G. P.

OXYURIS VERMICULARIS IN THE SKIN,

BY

MICHELSON. (Berl. Klin. Wochensc, 1877, No. 33.)

In March last, a thirteen year old and apparently healthy boy was brought to Michelson suffering with an eruption that resembled an eczematous intertrigo of the genito-crural fold, and encroaching upon the scrotum and thigh. The cause of the eruption was at first not apparent; but, upon microscopical examination of the crusts and scales, he found eggs and embryos of the oxyuris vermicularis in various stages of development. Further examination of the patient, showed that the parasite had been conveyed from the rectum to the seat of the eruption through the medium of a soiled shirt-tail. Warm baths and a dusting powder consisting of one part salicylic acid and one part starch relieved the cutaneous difficulty in a few days.

H. G. P.

ABOUT BOOKS.

A Compend of Diagnosis in Pathological Anatomy. By Dr. Johannes Orth. Translated by Frederick Cheever Skattuck, M. D., and George Kraus Sabine, M. D. Revised by Reginald Heber Fitz, M. D. New York: Hurd & Houghton, 1878, pp. 440.

This work is not designed to be an exhaustive treatise on pathological anatomy, but rather a practical guide to the student and practitioner for the performance of an autopsy. It is now some years since the appearance of Dr. Francis Delafield's able work on post mortem examinations, and very many changes and advances have been made since that time, so that the appearance of the present volume is not premature. At the same time Dr. Orth has already gained such an extended reputation as an original investigator, and a careful, painstaking observer, that a translation of his work in this country will probably be as successful as the original in Germany. The translators tell us in their preface that much new matter has been added to the original German edition, translated from manuscript still in the hands of the author and being collected by him for a subsequent German edition. Two new plates have likewise been added, illus-

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trating the method of opening the heart, and the anatomical points requiring consideration in the removal of the sternum. These are a valuable addition.

The chief value of the work, we think, consists in the number of practical suggestions given, and the descriptions of the methods to be pursued in the study of morbid anatomy. Indeed, this has been the author's principal aim, and he has kept it in view throughout the whole of the work. A great deal of such practical knowledge can, of course, only be gained by actual experience in making post-mortem examinations; but, as the author truly remarks, "in order to make this experience the more profitable, it is necessary that a theoretical knowledge should first be acquired, not only of the course and method of the examination, but also of the alterations which may take place in the several parts, and of their characteristic peculiarities. This is all the more necessary, as but few students or physicians are able to secure special opportunities for practical training." And we may add to this, that in the present state of medical science, it is necessary for every intelligent practitioner to possess the kind of information of pathology that is contained in this volume.

The views of morbid anatomy that are set forth are chiefly those of Rindfleisch and Virchow, of whom Dr. Orth has been such a distinguished pupil.

The table of contents is very complete, "serving also as a brief recapitulation of the progress of an autopsy," and we will simply mention a few of the principal headings to give an idea of the scope of the work. The introduction describes preliminaries, instruments, etc. Examination of the body, A. Inspection—the body as a whole, its parts, of new-born children, skin, and subcutaneous tissues, under which is included the pathology of all its diseases. B. Internal examination—I. Spinal canal. II. Cranium, including all diseases of the brain and membranes. III. Thoracic and abdominal cavities, pericardium, heart, lungs, etc. B. Peritoneum, spleen, kidneys, pelvic viscera, duodenum and stomach, gall-bladder and liver, pancreas, intestine, great vessels, and lymphatics, etc. IV. Extremities, joints, bones, etc. This is, indeed, a very imperfect condensation, and gives little idea of the completeness of the work.

As regards the translation, as far as may be judged by the comparison of certain portions with the German original, we may say that it is excellent. The reviser remarks, with truth, "a correct translation has been deemed of greater importance than an elegant one," though there is no need of apology, as the book reads very smoothly, and is free from those grossly misconstructed sentences so frequently met with in translations from a foreign language, especially the German.

The publishers have issued the book in their usual handsome style, having printed it on good paper, with large type that does not call for any extra effort on the part of the physician's eyes to read—something that cannot be said of many medical works published at the present time.

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THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY,

A Semi-Monthly Journal of Medicine and Surgery,

EDITED BY

EDWARD J. BERMINGHAM, M. D., and FREDERICK A. LYONS, M. D.

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LECTURES.

LECTURES ON PARALYSIS AND CONVULSIONS AS EFFECTS OF ORGANIC DISEASE OF THE BRAIN.

Delivered at Bellevue Hospital Medical College.

BY

C. E. BROWN-SEQUARD, M. D., ETC.

LECTURE V.

GENTLEMEN:—You may remember that a fortnight ago I examined the question relative to the diagnosis between cases of disease of the various portions of the base of the brain, and cases of disease of other parts. I said that paralysis caused by disease of some portions of the brain, is sometimes very difficult to diagnosticate from that caused by disease of other parts, but I gave you some points that will enable us, in many cases, to come to an accurate conclusion. Among the symptoms that I did not mention, there are a few that will now receive our attention.

When the paralysis is located on one side of the body from disease of the pons Varolii, if the face is paralyzed, and it almost always is

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from a lesion in this location, the paralysis will be on the opposite side in most cases. It may be on the same side, and the difference exists according to the seat of the lesion. If it be low down near the medulla, the roots of the facial nerve will be affected, and we shall have alternate paralysis. If the lesion be in the upper part of the pons Varolii, the symptoms are different; the paralysis of the face will be on the same side. In most cases, however, the paralysis of the face and limbs are on opposite sides of the body. In disease of this portion of the base, there is one important feature which must not be overlooked. If you look at a patient suffering from paralysis from brain disease in this locality, you will notice something that is absent from most other cases. This is a lack of power in closing the eye. The orbicularis muscle of the eye is paralyzed only in cases of disease of the pons Varolii. You usually do not find this particular symptom in other cases. If you tell the patient to close his eye, he cannot do so. In this feature there is a characteristic difference from other cases, showing that the disease is in the pons Varolii, or is not there. When this symptom is present, there is really almost a certainty of the existence of disease in the lower part of the pons Varolii. This is an important point, as you will see in my last lecture of the course, for the means of treatment is not the same when there is a difference in location of the lesion.

There are still other symptoms that show when the disease is situated in the pons Varolii or medulla oblongata. Among the number is a symptom called nystagmus. This consists in a trembling to and fro of the eyeball. It seems to the patient that the objects in his vision are trembling and moving to and fro, for the trembling of the eyeball gives him that delusion.

Still another feature of interest consists of a symptom that has only been studied during the last twenty years. Vulpian, of Paris, and Prevost, of Geneva, first called attention to it. It consists of a turning of the neck to one side, and a conjugated deviation of the eyes to the same side. If you look at my head drawn over to the left shoulder, and my eyes looking in the same direction, you see an instance of conjugated deviation of the neck and eyes. This is a frequent symptom in cases of softening of the brain, and likewise in cases of hemorrhage in that organ. As regards this symptom, there is something peculiar in this respect, viz:—In cases of disease elsewhere than in the pons Varolii, the tendency of the head and eyes shows itself toward that side in which the injury exists. This symptom comes on, the same as convulsions, wherever the disease is in the brain. The head turns to the side of the disease. If the lesion be on the left side of the brain, the head and eyes turn to the left; and, on the other hand, if the lesion be located on the right side, the head and eyes turn to the right. In most cases you will find the head turned away from the paralyzed side, toward the sound side. Now, when the disease is in the pons Varolii, we very frequently have the reverse of this condition, the head and eyes being turned towards the paralyzed side

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of the body, and not towards the injured side of the brain. Here, then, is a diagnostic point between disease of the pons Varolii and other parts of the brain. Still, there are cases in which the deviation occurs in the wrong way. Instead of being to the side towards the injury, or *vice versa*, it may be to the opposite; but, in most cases, the rule I have mentioned holds true.

Before passing to other parts of the nervous system, I must tell you that there are two things which I should like you to remember, that show conclusively that our doctrines, as regards the physiology and pathology of the brain and cord, are so wrong that they deserve no credence. These two facts are: *First*—There are many cases on record in which, without any marked paralysis having been observed, the pons Varolii and medulla have been in a great measure altered. Indeed, a very few fibres of communication between the upper part of the brain and the spinal cord are sufficient for the persistence of all voluntary movements. If this fact be true, that only a few fibres, in comparison with the great numbers that exist, are sufficient for the communication between the brain and spinal cord, you can easily understand how it is that, in some cases, large portions of these parts of the brain may be destroyed without symptoms, as in the case related by Stanley, of St. Bartholemew's Hospital.

This case was that of a sailor who died without any symptoms of paralysis; yet, at the autopsy, the medulla was found so reduced in dimensions that it did not measure one-fifth of its ordinary size. An exostosis was found blocking up the channel between the cranium and the spinal canal. The aperture of the foramen magnum was reduced so much in size that it was impossible to pass the little finger through the opening. Still the man acted as a sailor, and did all of his ordinary duties as such with his ordinary undiminished power; and he died of another affection, without at any time having any kind of paralysis.

There are many other cases of the same kind of equal force. The odontoid process has been enlarged and caused pressure on the medulla, rendering it extremely small. In such a state, it could not be healthy. The medulla in this state, when cut, gives a hard, cheesey appearance. In a case by Beamis, in which no paralysis was observed, a microscopical examination of the medulla showed that not a single fibre remained healthy. Most of it was transformed in a tumor, and what remained showed a considerable alteration. There are, then, a great many cases of partial or total destruction without any *marked* paralysis. I say *marked* paralyses, for these writers say there was none whatever; but I allow for the inadequacy of our means of determining paralysis.

Such facts may seem very strange to you, especially when you know that the pons and medulla are most delicate parts, and in which a sudden injury proves instantaneously fatal in many cases. A mere prick in the medulla will kill an ox. You well know that in Spain, after the bull fights, the means of killing the wounded or infuriated animals, consists in passing a poignard through the muscles of the neck

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into the medulla. In small animals this is very easily done, and a mere prick in the medulla causes death invariably. Although death is caused so easily by injuries in this location, lesions, coming on gradually, may cause alterations in the structure without symptoms. In many cases of hemorrhage into the pons Varolii, no signs of paralysis may occur. Hughlings Jackson has seen one of the numerous contradictions between the facts as they are, and as they should be in such cases. In sudden injuries and gradual diseases in these parts, not only has death not supervened, but even no symptoms of paralysis have been manifest.

The second point is also most important in this connection, and shows that the old views must be laid aside as they are in opposition to thousands and thousands of facts. What I have said clearly shows that no decussation in the base of the brain is essential for the conduction of motor impulses. What is usually taught consists in admitting that paralysis appears on the opposite side of the body, from the disease in the brain on account of the pretended decussation of the motor fibres, those from the right and the left crossing to the opposite side in the pons or medulla, or in both. The decussation, it is easy to show by facts in very large number, does not exist there. I have already pointed out to you a number of these facts. There are a number of decussating fibres, it is true, but they cannot be voluntary motor fibres. You cannot admit, in the face of these facts, that the voluntary motor fibres decussate in the pons Varolii or medulla. If I show, besides this, that there is no part of the brain in which the decussation exists, we must admit that there is no decussation.

Anatomy teaches that the bonds of union between the brain and the spinal cord are the crura cerebri, pons Varolii, and medulla oblongata. The cerebellum has never been looked upon as the bond of communication, and it would be absurd to do so, because there have been a number of cases of disease of the cerebellum without producing any paralysis. The only channel admitted by every one, is the front part of the base of the brain. The question, as regards paralysis, is, whether there is any decussation.

Suppose there is a disease in the pons Varolii, destroying everything there, and there are a great many such cases, we should have paralysis on both sides of the body, but this does not always happen. Suppose, again, that the pons is destroyed in one of its halves. In most of these cases, not in all, but in most of them, the paralysis occurs on the opposite side of the body, and it may be absolute. Now, what conclusion do we draw from this? It seems clear that the fibres serving for voluntary motion on the opposite side of the body all pass here, that is, on the side that is injured, as the paralysis is complete on the opposite side of the body. If you admit this fact, you must also admit the fact that the decussation does not include the voluntary motor fibres. If it did, you would have paralysis on both sides of the body, as in destroying one-half of the pons, you would destroy the fibres belonging to the two sides of the body, those for the one side

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which have not yet decussated, and those that have already crossed over from the opposite side. If, therefore, the voluntary motor fibres decussate in the pons, a leison on one side would produce paralysis in the two halves of the body and not only on the opposite side as it happens in most cases. The conclusion is positive, as we see in most cases that the paralysis occurs only on the opposite side, and in one clear case it occurred only on the same side.

We must likewise reject the view of Schiff, and others, that decussation takes place in the medulla oblongata and there only. The fibres that decussate lower down are very numerous, indeed. If the fibres decussate in the medulla oblongata and are injured above their crossing the facts would be easily explained. I believed that such was the case for a long time, and I published an article a long time ago, proving that the whole decussation was in the medulla, and facts were abundant which seemed to prove this opinion. If the disease is in one-half of the brain, a degeneration takes place in the fibres going down on the same side, until it reaches the anterior pyramid, and there it seems to cross. I think it can be proven, however, that decussation does not take place. If this is so, the decussation that is seen is not at all employed in conducting voluntary motor power, the voluntary motor fibres do not decussate in the brain at all. What are the facts? There are many cases of disease in the spinal cord without any paralysis at all. The olivary bodies, the corpora restiformes and the anterior pyramids can be destroyed without any paralysis at all on the opposite side. Experiments in animals show that in many cases division of the anterior pyramids produces no paralysis at all. Section here, cannot prove anything but what is clear, that no effect is essential in section of one-half of the medulla oblongata. If decussation of motor fibres occurs this could not be so.

If disease can destroy both halves of the anterior pyramids, as in the case of Vulpian, where a man walked into the hospital without any symptoms of disease of the brain and died soon after. The autopsy showed that almost the whole of the fibres of the anterior pyramids were destroyed or atrophied, it is clear that there can be no decussation of voluntary motor fibres in this location.

If we put these facts together, we will find that the voluntary motor fibres do not decussate in the pons Varolii or medulla oblongata, and as there is no other part where we can discover a decussation of fibres, it is clear that the fibres which compose the decussation are not the voluntary motor fibres. The other result that follows from this is, that the paralysis which we find almost always to be on the opposite side of the body cannot depend on the destruction of voluntary motor fibres.

This result we come to, not only from facts relating to paralysis, but also to convulsions, rigidity and stiffness of the muscles, chorea, tremulousness, and catalepsy can appear on the same side as the injury to the brain. So that we are not to look to convulsions

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as establishing decussation. If we look to cases of disease of the crura cerebri, pons Varolii and medulla oblongata, we will find them with convulsions on the same side of the body. If the fibres of decussation were conductors of voluntary motor power, we should *always* have convulsions on the opposite side of the body. You could not have anything else, but as disease on one side of the brain has produced convulsions on the same side of the body, it is clear that fibres of decussation are not what they are pretended to be, viz., voluntary motor fibres.

I have now to come to some other points, but I will take this subject up again in one of the last lectures, and try to show by what mechanism the will acts on the muscles, and also show some points of diagnosis when the facts seem to be in disharmony.

We come now to the diagnosis of disease in the cerebellum and crura cerebelli. I will say that any one that could give an hour or two to the study of cases at random, would at once learn immensely in this respect. Almost any symptom can appear, and no one symptom is constant. The symptoms of disease of the cerebellum are varied, no matter what it is used for. I do not know what its office is, but if it serves for anything, it is an organ for the production of nerve force.

The most constant symptom produced by cerebellar disease is a general weakness. Even when the paralysis is only *local*, a *general* weakness exists. If there is nothing essentially belonging to disease of this portion of the brain, there are many symptoms that frequently appear with it, so that if a paralysis coexist with these symptoms, it may lead you to expect that the disease is situated in that locality.

A loss of sight is a very frequent thing in these cases. Why, you will say, is this so? With the views I have given you, that any symptom may come on from disease in any part of the brain, it is easy to make such a symptom come under the rule. There is no connection, directly, that is to say, between the loss of sight and the cerebellar disease. It may be said that the lesion causes pressure on the tubercula quadrigemina from its close contiguity, a tumor will exert such pressure. If it be true that the centres of vision are located in these organs, the fact would be in harmony with such a theory. But what of those cases in which there is no pressure and the loss of sight exists, and still more, how is it in the cases I shall presently mention. Disease in the cerebellum alone may produce amaurosis of one or both eyes.

There is still another point. There are many cases of disease in the cerebellum of slight extent, and in which no pressure whatever was exerted on other parts of the brain. A condition of softening or inflammation in the cerebellum has caused amaurosis in the same way. This phenomenon is of the same nature as what occurs when teniæ or lumbricoides in the bowels cause amaurosis either in one or other, or in both eyes.

Some medical men have tried to explain this loss of sight in cere-

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bellar disease by saying that it is due to effusion of serum into the ventricles, and caused by disease of the cerebellum. It is true that in some cases there is considerable effusion of serum in the lateral ventricles. This comes from the fact that the sinuses of the brain are pressed upon by the disease in the cerebellum, and the circulation is thereby obstructed in one or both halves, according as the pressure is exerted on the veins. It is easy to admit such a cause in some cases, and the theory seems in harmony with the facts, but there are cases in which no serous effusion has been produced.

The truth of the matter is this, that a change in other parts of the brain can be caused by a disease in the cerebellum. The nutrition is altered, or there is the production of inhibition, or the phenomena of the arrest of function, which I consider the great point.

What are now other symptoms which show that the paralysis depends on disease of the cerebellum? There are two other symptoms that are more or less constant. Headache in the back of the head, more violent, perhaps, than in any other case, and vomiting. The vomiting, I need not tell you, is caused by contraction of the muscles of the abdomen and diaphragm, and of the walls of the stomach. If you take the view that contraction of the muscles takes place from irritation of conductors or centres, how can you explain the vomiting? There are no fibres connecting the cerebellum with the stomach. No one has ever supposed the cerebellum to be the centre for the stomach and for digestion. The vomiting is a reflected symptom. An irritation is transmitted to cells at a distance, other cells at a distance are put into play, and these act by putting into play the muscles of the abdomen, the diaphragm, etc., and thus the vomiting is produced.

Still another symptom to be noted is the great deal of disorder in the movements, which is exhibited. The patient seems drunk when he attempts to locomote. If he walk at all, he progresses like a person intoxicated by alcohol. This symptom is not like what occurs in locomotor ataxia. You know that in what is called locomotor ataxia, where the disease is situated in the spinal cord, instead of planting the foot down firmly in the straight direction, the foot goes sideways, and comes down, not on the flat, but on the heel. This symptom that we are speaking of as being present in disease of the cerebellum, is not like that seen in locomotor ataxia, but something different. Sometimes it is marked; sometimes it is not. The patient totters when he closes his eyes. There is lack of proper balancing power in the system.

This symptom occurs in many cases of disease of the cerebellum; but, from the fact that it does so, you are not to conclude that the cerebellum is the centre for equilibration.

It has been said that this organ is the centre for the muscular sense. The same thing as Flourens indicated, although he did not give it a name. The guiding power is lost in these cases, and there is a state of apparent drunkenness.

The appearance of this symptom is not due to the loss of the centre

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controlling movements, because the destruction of a great part, or even the whole of the cerebellum, may occur without the loss of this power. If the centre for controlling movements were situated in this place, we ought always to have loss of this power when there is disease in the cerebellum, which I have already said is not true.

ORIGINAL ARTICLES.

ALIMENTATION IN SURGICAL ACCIDENTS AND DISEASES, AND ITS GENERAL VALUE AS CONTRASTED WITH THE VALUE OF MEDICINE.*

BY

FRANK H. HAMILTON, M. D., LL. D.,

Surgeon to Bellevue Hospital, Etc.

The old and homely adage, "starve a fever, and stuff a cold," probably teaches a double fallacy. At any rate, in the light of modern experience it would be an error to starve a fever; and it is not quite clear that it is well, in all cases, to stuff a cold; yet the second limb of the proposition is much nearer the truth than the first.

It is believed, to-day, that nearly all fevers are brought to a more speedy and satisfactory termination, if, during their existence, the vital functions are supported by nutriment, judiciously administered; and the practice is now considered "judicious" when nutriment is administered with a liberality not deemed safe by our fathers.

These later opinions seem to be sustained by careful observation, and they are at present taught by all of our most experienced and intelligent medical writers. Comparatively few, however, have sought to enforce the same doctrine when speaking of surgical accidents and diseases, or of chronic local inflammations. Yet I am persuaded that most surgeons entertain opinions in harmony with my own, and that their practice has in this regard—that is to say, in the matter of alimentation, undergone within a few years the same change as has the practice of physicians in regard to fevers. In what I have to say upon the subject, then, I do not pretend to originality; but my purpose is simply to record and give prominence to certain accepted maxims of practice which have not yet received the form of precepts.

The doctrine which I desire to support is, that nearly all surgical accidents and diseases demand alimentation—that furnishing such nutriment to the heart and lungs, and to the other vital organs, as shall enable them to perform their respective functions without labor and with fidelity, seldom or never causes an increase of existing inflammations, or aggravates traumatic fevers or other general disturbances dependent upon traumatic accidents. On the contrary, the doctrine teaches that most traumatic fevers and inflammations demand

*Read before the New York Academy of Medicine.

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nourishment as one of the most important, and often absolutely essential means of prevention and of cure.

When surgeons began to treat surgical accidents without the use of the lancet, the first important step was taken in the reform of practice in this direction. You know it is not long since, that when a man was shot through his lungs or belly, he was at once bled to prevent inflammation; and if the inflammation was not prevented, as in most cases, certainly, it was not, the patient was bled again and again to syncope. From three to a dozen bleedings were sometimes required to terminate the case; yet, in spite of the bleedings, the case did not always terminate favorably. The inflammation was sometimes only extinguished when death occurred. Men were bled, and leeched, and cupped for sore eyes and for sprained ankles, and for bruised shins, and for broken bones; and women were bled, and leeched, and cupped for inflamed breasts, and for the traumatic and septic fevers consequent upon childbirth. All this, with us, is changed now. During our great civil war, I never saw a surgeon bleed for a gunshot wound, and blood-letting is almost an obsolete term in modern gynæcology. I am speaking particularly of what has occurred in my own country; for I know less of the changes in opinion and practice which may have taken place abroad. On the continent, I believe, a marked change has taken place in the practice of surgeons since my first visit to Europe in 1844, and perhaps not so much in the practice of British surgeons, who still continue to bleed quite freely, in gunshot injuries especially. I must be understood, therefore, to be speaking only of American practice, in reference to which my knowledge is more precise.

When bleeding was so much practiced, antimony and low diet were its natural and inevitable adjuncts. Antimony disappeared with the lancet; but low diet, and "absolute" diet—a term employed to designate the extreme of low diet—have held their ground longer than the lancet or antimony. Even physicians, who were the first to abandon the system of low diet in fevers, did so reluctantly, and not until long after they had given up the lancet. Thinking, probably, that if experience had shown that the quantity of blood in the system had less to do with the progress and severity of fevers than they had formerly supposed, its quality, at least, must be considered, and that nourishment rendered the blood more stimulating, and thus supplied fuel to the fire. This opinion they no longer entertain, or, to say the least, it is very greatly modified.

In the practice of surgery, I now very often hear the value and importance of nourishment spoken of where formerly a low diet was enjoined, and this seems to me to be the second step (a less resort to the lancet being the first) which surgeons have taken or are prepared to take, in the treatment of surgical accidents.

I take this opportunity of saying that, possibly, as has been hinted now and then by late medical writers, the type of fevers and of inflammations has undergone a change in the human family, and especially

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since the period when the Asiatic cholera spread over the world, or since the period when typhoid fevers became more prevalent, and that possibly the general use of anæsthetics has determined a change also in the character of traumatic inflammations. In view of which possibilities, one change in practice would not imply that physicians and surgeons were in error when they adopted in all these cases what was then spoken of as the "antiphilogistic" treatment; but that the diseases having changed, an observing profession had properly changed its practice, also, to suit the new exigencies. These points I do not propose to discuss; but only to state my conclusions from the facts as they are now presented in our daily experience.

There ought to be no misunderstanding as to what is meant by alimentation in diseases or in traumatic injuries. Food, that is, meat, vegetables, etc., are not of necessity aliment simply because they have been conveyed into the stomach. They need to be digested and properly assimilated before they can be regarded as nourishment; and it is unnecessary to say that the stomach, with the other organs of digestion, are not always in a condition to extract nourishment from all kinds of food, or even from the most nutritious food; but that, on the contrary, the digestive organs are notoriously capricious, refusing at one time what they readily appropriate at another. These conditions unfavorable to assimilation being present often when we consider ourselves in health; but they are almost constantly present, in a greater or less degree, immediately after the receipt of a severe injury, and in many cases during prolonged local disturbance; that is, during the progress of recovery from severe local injuries, digestion and assimilation wait on appetite.

A severe shock o the nervous system, such as is produced by a grave injury, by a painful and exhaustive surgical operation, by prolonged anæsthesia, and by sudden and afflicting news, may for a time paralyze nearly all the functions of the body, if they do not cause speedy death; and in this general paralysis, the stomach participates with the other organs, in consequence of which digestion suddenly ceases or is greatly impaired. The food which may have been at the moment contained in the stomach, remains to undergo putrefaction, and becomes a source of irritation and of distress, causing, in some cases, nausea and vomiting, and in other cases a copious diarrhœa, or both at the same time. The occurrence of either of which phenomena may be regarded as a natural and safe mode of relief; but if neither occurs, a complete restoration of the powers of digestion and assimilation cannot be looked for until the offending matters have been removed by the aid of drugs, or more slowly by delay and simply omitting to urge food upon the stomach for several days, during which time this organ will, in most cases, gradually unload itself.

It may happen, also, that for a considerable time after the offense is removed, the stomach will remain irritable or exhausted, and fail to perform its duties, demanding appropriate medicines to overcome these derangements.

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Under these conditions, and probably under others which have not been named, rest or medication may be most important, and ought to precede all attempts at alimentation; and simply because alimentation is now impossible. But the time soon arrives, in nearly all cases, in which alimentation is possible, and then there ought to be no delay in the use of appropriate food. I say *appropriate* food; for it is well enough to repeat that a rich man may starve while attempting to extract nourishment from plentiful supplies of tough or badly cooked meats, or from food which, while it is in all other respects unobjectionable, is to the patient's capricious stomach disgusting or simply distasteful, and will not, therefore, either provoke a flow of saliva or of gastric juice.

If the food is not appropriate, the patient who receives it will not only suffer from lack of nourishment, but also from the irritation caused by the presence of undigested, and, consequently, irritating materials. *Such attempts at alimentation will certainly increase febrile action and aggravate inflammation.*

The fact is, however, that examples are exceedingly rare in which some feeble ability to digest food does not exist; and even in these exceptional cases, a judicious selection and timely administration of certain articles seldom fails to produce an appetite, or at all events to convey to the system some nutrition. A warm, well seasoned and well cooked cup of broth, or a fragrant cup of hot coffee and milk, will often relieve nausea and epigastric distress, assuage a colic, diminish the severity of a headache, lift the tone of the nerves suffering under shock; and the same or similar means will often abate sensibly febrile disturbance and soften the pains of inflammation. Who ever knew of harm from food under these circumstances, when carefully and judiciously administered? I am, at least, certain that for every case in which it can be shown to have done harm, twenty cases will be found in which it has done good.

Medicines—so-called—are in general far inferior to a fragrant and savory cup of food, as peptic persuaders, and I have seen many patients suffering with nausea and loss of appetite, who have been speedily relieved by the mere omission of the bitter and disgusting tonics which have been forced upon their reluctant stomachs. It is true that, under the circumstances referred to, now and then good medicines do good and improve the appetite; and their occasional abuse or unskillful exhibition is no reason why they should never be used. Nevertheless, I wish to say, very emphatically, that the abuse of medicines is more than "occasional." It is alarmingly frequent. It is a simple elementary truth, that there are many diseases and surgical injuries in which recovery takes place as speedily without medicines as with medicines; and if any medical man has not learned this, and continues to give drugs from day to day for every form and grade of human ailment, so much the worse for him and for his patients.

But if men can live and recover from disease sometimes without medicine, no man can live or recover from disease without food.

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Organs which are maimed and struggling must have food, or they will soon cease to labor, and will die. A wound will not heal nor a bone unite without nutriment. In every human malady and surgical accident, repair and recovery wait on nutrition.

It is not improper, then, to say that as a means of restoring the sick and wounded, when both may be needed, good food is of more importance than good medicine. Large armies have always suffered more from a deficient supply of proper food than from a deficient supply of proper medicines.

One conclusion to which my statement of facts and process of reasoning leads me is that hospitals and dispensaries ought to have the means and appliances for supplying to the sick, infirm, and maimed who come to them for help, not only medicines and skilled medical and surgical services, but also an abundance of nutritious food; indeed, that the question of food ought to be the first, where it is generally the last consideration.

There is an impression among many laymen, who have the charge of hospitals, that "extras," including eggs, milk, etc., with the services of the "diet kitchen," ought to be reserved for the few who are very seriously ill, and that all the slightly ill or convalescent should be content with the "ordinary" diet of the hospital, which is seldom very attractive to even a sound stomach. Those who have had experience in the United States army hospitals know that this was never the theory or practice of these hospitals; but that all of the regular rations were commuted, and with the money thus obtained nothing but what might be termed "extras" were purchased.

If a man is able to eat hard-tack and salt pork, or tough beef and unsavory soups, he is able, generally, to go to work, and ought not to remain in the hospital. Though well in other respects, and detained only because his broken limb is not thoroughly repaired, it does not follow that he can eat and digest what he could easily master when working out of doors, and carrying brick-hods to the top of five-story buildings. If it is an object to get these men speedily out of the hospital, and thus save the taxpayers; if it is desirable to restore them soon to their families, of whom they may be the sole support, then it will be necessary to give them food which will encourage an appetite, and be easily digested by a stomach weakened by long confinement, sickness, and anxiety. They must be treated in this respect in the hospitals, as we—you and I—are treated at home, where the utmost care is taken to see that our food is suitable and appetizing; where, although we may have ceased to take medicine, so long as we find ourselves unable to return to our usual out-door duties, we are fed only upon "extras." These same poor people, inmates of the hospitals, if they were at home, in their own humble apartments, would be fed better, so far as the quality and mode of preparing the food is concerned, than they are in most public hospitals. No pains are spared, generally, to furnish to the poor all the medicine they need; but what they want most, and get the least, is good food.

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The medicines and liquors dispensed at Bellevue Hospital during the six months ending July 1, 1877, cost $7,750; and for all the charities and prisons under the charge of the Commissioners of Public Charities and Correction, these two articles cost, for the year 1876, $40,892; about one-fourth of which, the apothecary informed me, was for liquors; leaving a balance of about $32,200 as having been expended for other medicines than stimulating liquors. Possibly a much larger sum has been expended for "extras" in the same institutions. Upon this point I am not informed, but my long connection with this, and other civil hospitals, enables me to say that it is generally more difficult to obtain proper food, and a supply sufficient for the demand, than it is to obtain good medicines and in sufficient quantity.

In these remarks there is no imputation upon those excellent and humane gentlemen who are in charge of these institutions. In my opinion we are alone responsible for this state of facts, inasmuch as we have hitherto failed to urge upon them and the public the greater importance of nutriment and the comparatively less importance of medicine.

Some intelligent men and women, not of our profession, have seen the want before we have, and they have established in various parts of the city diet kitchens, to supply the very want of which I am speaking, and which are properly made subsidiary to the dispensaries. There ought to be one immediately connected with every dispensary, and in the same building as the drug store now is. Indeed, I would be glad to see one-half of the drug stores, and all of the liquor stores converted into diet kitchens. I am not quite certain that they need all to be elemosinary in their character. It is possible they might, some of them, be self-sustaining. They will not have to be taxed like liquor shops, to pay for the crime and pauperism they create—nor will they kill as many people by accidental overdosing as do drug shops, not to speak of the deaths from overdosing caused by the prescriptions of illiterate and careless doctors. Those who have them in charge will not require a very long apprenticeship, and need know nothing of latin.

Very few of their materials will have to be imported, and they will require very little advertising, so that all in all these diet kitchens can be run very cheaply.

You will not consider it out of place, I trust, if I read to you the opinions of a professional athlete, Mr. J. M. Laflin, as reported in one of our morning papers—the *Herald* of October 21, 1877. He is speaking upon the subject of diet in training.

"In the first place, there are at the present day many young men who are preparing or training for athletic pastimes or pursuits who naturally apply for instruction as to diet to some professional athlete, who gives them the stereotyped advice: 'Eat plenty of rare meat.' Now this advice would be all well enough, perhaps, if the stomach of the one asking advice was as strong as that of the one giving the

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advice; but it is not, of course, and so, as it requires a great deal of tone and strength in the stomach to digest rare meat, the beginner in athletics finds himself unable to digest the rare meat he eats.

"Then in the second place, nothing is well digested in the stomach against which the palate revolts. In many instances—myself, for example at first—the taste of very rare meat is very unpalatable indeed, and to overcome this difficulty, recourse is had to all sorts of spices and condiments to render it more pleasant. Most spices and condiments are pernicious in the long run to digestion, and so rare meat, eaten under these conditions, becomes positively injurious.

"Meat ought to be neither rare nor what is called well done, but medium, so as to be palatable without spices, etc., while at the same time it retains a large share of its natural juices.

"More harm has probably been caused by this notion of rare, underdone, bloody meat being wholesome, than by any other idea on the whole subject, and the very first thing, young men, especially young men luxuriously nurtured, who take a personal interest in athletics should do is to abjure this notion altogether."

In these opinions I fully concur, and if Mr. Laflin's opinions are sound in reference to the eating of raw and highly seasoned meats by those who are in health, it is quite certain that this, to civilized palates, disgusting and over seasoned food is unsuitable for the sick, and it would be well if medical men would give attention to the common sense and practical remarks of this gentleman.

GENTLEMEN.—The remarks contained in the proceeding pages are by no means intended to be exhaustive of the subject of which they treat. They are simply suggestive, and are intended to call attention to a point in the therapeutics of surgery upon which, as it seemed to me, too little had been said and written.

In order that you may better understand what these suggestions are, and that, in the discussion which is to follow, you may be prepared to give with more directness your assent or dissent.

FIRST.—Chronic or low and persistent forms of inflammation are most apt to occur, idiopathically and as a consequence of traumatic lesions, in persons who are imperfectly nourished, and they are followed by the most serious results, such as ulceration, caries, necrosis, etc.

SECOND.—Chronic inflammations are seldom permamently overcome until by proper nutrition the general system is brought up to the standard of health. Not until all the various functions of the body are performed with vigor and fidelity—a condition which implies perfect nutrition.

THIRD.—Acute inflammations are most apt to occur, idiopathically, or as the result of traumatic lesions, in persons who are imperfectly nourished; and are followed by the most serious results, such as suppuration, pyæmia, erysipelas, etc.

This statement is not inconsistent with the fact that people grossly fed, and intemperate in the use of stimulating liquors, such as gour-

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mands, beer drinkers, whiskey drinkers, etc., are notoriously liable to rapid and destructive inflammation, as a consequence of traumatic injuries.

These people although they may be fat and ruddy, and although they may possess, as do the beer drinking porters of London, great muscular power for momentary exertion, have no endurance, and never make good soldiers. It is true they are probably sufficiently nourished, that is they have taken in and assimilated a sufficient quantity of proper food, but its quality is changed by the large amount of effete and inflammatory elements with which the blood is constantly loaded. These men are not, therefore, in any proper sense healthy, or *well*-nourished.

Nor is the statement contained in this third proposition, inconsistent with the fact, that people who are simply fat, but who are not intemperate in eating or in drinking, are, perhaps, more subject to inflammation, or to say the least, to some of its dangerous sequalæ, especially suppuration. Fat implies nutrition, but not, when in excess, healthy nutrition. Fat is a tissue of low organization, and under inflammation, is peculiarly liable to destructive metamorphoses.

Finally, acute inflammation and its sequalæ or accident are least liable to occur, and are most easily prevented in the well nourished, but temperate, thin and dry people.

FOURTH.—It seems a necessary corollary from the preceding or third proposition, that in order to the prevention of acute inflammation after traumatic injuries, and in order to cure acute inflammation after it has commenced, and in order to prevent its accidents or dangerous sequalæ, it is well, if not absolutely necessary, to nourish the patient through each of these several periods.

I believe this to be true, yet there are some facts of experience which seem to render the truth of the statement questionable; and it is, perhaps, the only one of my several propositions which is liable to a challenge.

There can be no doubt that bleeding, antimony, cathartics, with absolute diet and cold applied locally, that is to say, the old-fashioned "Antiphlogistic" treatment has often and may again bring certain acute traumatic inflammations to an abrupt and favorable termination. It will be another matter to consider, whether the same end could not have been accomplished as speedily by other means, and with less strain upon the vital forces, and with less danger of subsequent accidents and relapses. The question, at this moment, is, whether acute inflammation has ever yielded to "antiphogistic" treatment, and I answer that it has, but probably more often formerly than now.

The farther question which at once suggests itself is, with this admission, how are we to reconcile the fourth proposition, namely, that nutrition does not prevent, but probably aids in the cure of acute inflammation?

The line of argument by which I reconcile the apparently conflicting propositions is this:

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A. Antiphlogistic measures are means calculated to relieve temporarily local congestions, and consequent stasis, and painful pressure which are among the first link in the chain of inflammatory processes, and that they do nothing more, and if they fail in this, as unfortunately they do in too many cases, then they have in no way abated the inflammatory process, while they have rendered the tissues doubly susceptible to its destructive influence.

B. My own experience in the use of nutrients preceding the occurrence of traumatic inflammation and during its progress, has brought a conviction that nutrition is at all times harmless and often necessary.

C. It seems to me, as I have stated before, a necessary inference from the third proposition, the correctness of which proposition will not probably be questioned.

FIFTH.—Food is not of necessity aliment. It ought to be appetizing and digestible.

SIXTH.—The stomach is not always in a condition to digest and assimilate food; but this condition is exceptional. Such cases demand rest or medication.

SEVENTH.—Anæsthetics, morphine, and narcotics, generally impair digestion, and this fact should always be taken into consideration when for sufficient reason their exhibition becomes necessary.

EIGHTH.—There is a popular inclination to the excessive use of medicines of all kinds in the class of diseases now under consideration, as well as in all other diseases, and which medical men seem powerless to resist unless by adopting a fraud, pretending to give medicine when they do not. They often interfere with the success of our operations, and prevent recovery from accidents. My experience has been pretty large in this matter, and if my accuracy of observation has been equal to my opportunities, morphine has killed nearly as many men as have bullet wounds of the belly, not that most of these men would not have died of the wounds if let alone, but that the morphine has done sooner what the bullets would have probably done later.

Do not, gentlemen, understand me as denouncing morphine as a proper agent to be employed in bullet wounds of the belly, but only its abuse; an abuse which commences very often before the patients come under our notice; and especially is this true, in my experience, where patients have suffered injuries and are brought to the public hospitals. They are almost constantly overdosed with morphine when they arrive.

NINTH.—Nutrition is always safe and proper.

TENTH.—We need more good food for our patients—especially in the public hospitals—more diet kitchens and fewer drug stores everywhere.

Finally, permit me to say, that I am aware of the danger of accepting doctrines as a substitute for facts, which former are too often specious but unsound. It is not always safe in medicine to attempt even to formulate facts, but on the contrary, it is safer sometimes to let

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every fact stand alone and by itself, and thus compel each separate fact to force its own conclusions.

Whatever in the preceding remarks seems to be only theoretical you are not asked to consider, but only how far your experience in the managements of the class of injuries treated of, corresponds with, or differ from that of the writer.

In the debate which ensued upon the reading of the foregoing paper, Dr. Leonard Weber, while endorsing in the main the sentiments of the writer, considered that belly wounds demanded the use of morphine rather than nourishment.

To this Dr. Hamilton replied that the exception was well taken; that it was entirely true that in the case referred to, it was for a time more important to give morphine than nourishment; indeed, that at first morphine was necessary and food inadmissible; but the reason was this: the morphine was necessary to prevent that peristaltic action which always resulted from a wound of the gut, and which action was likely to increase the inflammation, and to expel the contents of the gut into the peritoneal cavity. It was also needed to allay pain, which was apt to be excessive in these cases. While, on the other hand, food must be prohibited, because the reception of either solids or fluids into the stomach was almost certain to awaken that peristaltic action which it was so important to prevent. Food was then withheld, not because nutriment would, in itself, aggravate the inflammation; but solely because it would prove an excitant to the muscular fibres of the stomach and intestines, in the same manner that a pebble or a glass of water would.

Dr. Hamilton said that his objection to morphine in these cases had only reference to its abuse. That it ought to be given in sufficient quantities to subdue pain, and to arrest the peristaltic action of the intestines; but that, when given to the extent of causing tympanitis and retention of urine, as it often was, it was hurtful. Whenever, in such cases, he found tympanitis, whether it was caused by morphine or the bullet, and it was generally the former, his prognosis was unfavorable. The tympanitis implied an arrest of the process of digestion, and the consequent formation of gases.

If this condition were induced by "shock," or by the activity of the inflammatory process, it would certainly be a sign of danger. When caused by morphine it equally implied a paralysis of certain functions and was in so far a complication, but the distinction of wounded intestines by gases must facilitate the escape of these gases into the peritoneal cavity, and with this explanation we can see how the excessive use of morphine in these cases increases or hastens thi s fatal issue.

Dr. Alfred C. Post thought the writer might not be fully understood, and that there were certain acute febrile states in which alimentation would not be tolerated. He also thought the question of rare or well

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cooked meats was a question to be determined by the kind of meat and by taste. Black meats require less cooking than white.

Dr. Andrew H. Smith remarked that in his opinion no more aliment would be assimilated in any case than the system actually required. This was found to be the case with the absorption of oxygen by the blood contrary to the views formerly held, and he thought that the same rule would hold good in regard to alimentary substances. Even if more were absorbed it would be promptly thrown off as excrementitious material, and would not constitute a hyperalimentation or hypernutrition.

HOSPITAL RECORDS.

COLORED HOSPITAL, NEW YORK.

Contributed by FRANCIS HUBER, M. D.

ANEURISM OF ASCENDING AORTA.

Jno. W., Va., laborer, 35. Brown skin. Admitted 3-13-76. Father and mother same color as self. Has one sister living and well. When young he had measles. Had gonorrhœa about two years ago. He has been troubled with rheumatism for past ten years. The attacks would last about six weeks at a time, and then patient would be free for months.

On admission patient complains of pain in chest, more marked on left side and shortness of breath, which he perceived about a month ago.

Also has pain in his left leg and is very restless at night. Bowels are regular.

Pulse, 76; Respiration, 20; Temperature, 99°.

Urine reddish, 1018; acid, very slightly albuminous.

Physical examination. Left side fuller than other. Resonance increased over both lungs. No rales or change in respiratory murmur.

Heart apex beat in fifth intercostal space, five inches to left of median line. A systolic murmur is heard most distinctly near the base and is propagated over a wide area.

Diagnosis, Aortic Stenosis and Hypertrophy. Treatment, tonics.

10-25-76. As patient complained of a constant pain in left side of chest, he was carefully examined a number of times for aneurism; always however with a negative result. The last physical was made about six weeks ago.

This morning a tumor was accidentally discovered on the left side. The patient says he first noticed it about a month ago. It has grown so rapidly that at present it has attained the size of a man's fist. The tumor projects from the middle of the sternum, between the line of second rib above and fifth rib below. Superiorily and inferiorily, its

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margins are quite abrupt; while latterly the prominence recedes gradually, especially on the left side where a secondary elevation between third and fifth ribs can be distinguished. Over the whole tumor pulsation is distinctly perceived. A loud systolic murmur with maximum intensity over left nipple is heard. Marked dullness exists over the most prominent portion of the tumor, and extends as far as left nipple.

The radials, carotids and femorals beat feebly. The tumor vertically measures four and one-half and bilaterally five and one-half inches.

Lungs healthy.

12–24–76. Patient is feeling comfortable. The tumor is increasing to the left.

2–5–77. Tumor is growing slowly, increasing downwards and to left. Very little pain is connected with it at present. Has had several attacks of articular rheumatism; quickly relieved by alkalies.

3–20. Suffers from frequent attacks of dyspnœa, generally coming on after a full meal. Aneurism gradually increasing in all directions. Is again suffering with rheumatism; ordered salicylate of soda

3–22. Under above treatment pain has diminished and tenderness is greatly lessened.

4–5. Tumor steadily increasing; at present measures seven inches in vertical and eight and one-fourth in transverse diameter. Uppermost portion is one and one-half inches below the suprasternal notch.

4–16. Small nodule, about the size of a hickory nut, presenting itself at upper portion of tumor, and gives evidence of softening.

4–22. Nodule spoken of in last note increased to size of large chestnut. It is very soft and epidermis on its surface is scaling off. Faint pulsation can be detected in it. A prominence immediately under it is also growing softer.

4–23. A slight oozing of blood took place from the lower of the two nodules. The blood was very dark and fluid.

4–24. A slight oozing from the larger nodule. In both cases the bleeding was easily checked by application of lint saturated with the lig. fer. subsulph.

4–26. Patient has been gradually failing for some time past. The emaciation is very great. At times complains of great pain connected with tumor. There is no evidence of pressure on œsophagus or trachea. Appetite is pretty fair. Up to a few weeks ago, patient was able to sit up.

4–27. For last fortnight has been compelled to keep in bed, because of increasing weakness.

Died very quietly at 2 P. M.

Autopsy eighteen hours P. M. Rigor mortis not very well marked. Body greatly emaciated. Brain not examined.

Pleuritic adhesions were found on both sides; in greater number on right. The left pleural sac contained about a pint of serum; considerably less was present in the right. Both lungs were compressed and

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carnified; the left weighed only thirteen ounces, and was about one-half size of right. No other abnormalities present.

The pericardium was greatly thickened, and very firmly adherent to the heart by both old and recent adhesions. The heart itself was twisted so that left ventricle was situated anteriorly.

The aortic valves were slightly thickened, especially at base; not contracted or fissured. About one-fourth inch above base of valves in the anterior wall of the aorta, an opening about five-eighths of an inch in diameter communicated with a large aneurism, about the size of a cocoanut. The aneurism had absorbed its way through the body of the sternum, and in addition had produced extensive erosion of the anterior and posterior surfaces of sternum, and the costal cartilages of the four or five upper ribs. The portion of the tumor presenting externally was of about same size as that situated internally. The arteries coming off from the thoracic aorta were all pervious.

Abdominal organs were not examined.

The absence of the usual symptoms in the earlier stage, the rapid growth and the uncommon origin of the aneurismal tumor, render the above case instructive and interesting. Though aneurism had been strongly suspected, and the patient carefully and repeatedly examined; physical exploration, prior to the perforation of the sternum by the tumor gave each time a negative result. The light thrown upon the case by the "post mortem fully revealed the difficulties in the way of an early diagnosis. Partly intrapericardial, and springing from the anterior face of the aorta, a short distance above the Valsalvian sinuses, the tumor developed in the region of cardiac dullness. The bruit, ordinarily so characteristic of arterial tumors, in this case, was most distinct in the region in which we usually seek for lesions of the aortic valves. Pulsation was obscured by the interposition of the sternum. The aorta not dilated at any point was of normal calibre throughout. The orifice in the anterior wall of the artery, through which the blood swept into the aneurism, was sharp cut, circular, and less than three-fourths of an inch in diameter.

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PERISCOPE.

COLLABORATORS.

Dermatology.—HENRY G. PIFFARD, M. D., Professor of Dermatology in the University of New York.
Diseases of the Nervous System.—EDWARD C. SEGUIN, M. D., Professor of Diseases of the Nervous System in the College of Physicians and Surgeons, New York.
Diseases of Women and Children.—FRANK P. FOSTER, M. D., Gynecologist to the Out-Patient Department, New York Hospital.
General Surgery.—EDWARD J. BERMINGHAM, M. D., Surgeon to the Good Samaritan Hospital for Diseases of the Rectum, and to the Out-Patient Department, Bellevue Hospital, New York.
Genito-Urinary Diseases and Syphilis.—ROBERT W. TAYLOR, M. D., Professor of Dermatology in the University of Vermont.
Ophthalmology and Otology.—S. B. ST. JOHN, M. D., Assistant Surgeon to the New York Eye and Ear Infirmary.
Orthopedic Surgery.—NEWTON M. SHAFFER, M. D., Surgeon to the New York Orthopedic Dispensary and Hospital.
Practical Medicine.—E. DARWIN HUDSON, JR., M. D., Professor of Practice of Medicine, Woman's Medical College, New York.

SOLID FOOD IN TYPHOID FEVER.

(Practitioner, November, 1877.)

BY

DR. SAMUEL D. TURNEY,

Professor of Diseases of Children, Starling Medical College, Ohio.

DR. TURNEY, early in practice, observed the similarity between the later stages of typhoid fever and the effects of imperfect nutrition. He came to believe that many deaths attributed to the disease were the results of unsupplied waste of tissues. A more liberal diet of nutritious fluid food—rich soups, beef tea, egg-nogg, and milk—was followed by milder symptoms, shorter continuance of the disease, and increased number of recoveries. As early as possible, before the stomach has lost its digestive power, he advises solid food—beef, mutton, roast potatoes, and toast. He advises little or no fluid at meals; patient is urged to eat, if only a few mouthfuls, and the habit kept up; in the course of three or four days, loathing of food ceases, it is readily taken, and even anticipated. *Pari passu* the gravity of the symptoms subsides, the course becomes mild, and the patient convalesces at the end of the third week, with no other therapeutic means. Contrary to accepted belief, Dr. T. asserts that solid food does not increase fever, or cause indigestion, gastro-enteritis, aggravated diarrhœa, ulceration of Peyers patches, hemorrhage or perforation.

E. D. H., JR.

MINOR THERAPEUTIC USES OF SALICIN.

BY

T. J. MACLAGAN, M. D. (*Practitioner*, November, 1877.)

SALICIN is of service in those cases of *neuralgia* in which pain comes on in periodic exacerbations, and in which quinine either fails

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to do good, or is for some reason inadmissible. It is as an occasional substitute for quinine that salicin finds its place in the therapeutics of neuralgia (coryza, rhinitis), *cold in the head.* The author cites four cases: *Case I.*—Adult; took twenty grains every two hours; perceptible relief after third dose; evening after ingestion of one hundred and sixty grains, cold entirely gone. *Case II.*—Boy of six years; bad coryza; took eight grains every two hours during day. In evening, after six powders, forty-eight grains, nearly well; in morning, cold cured. *Case III.*—Yound lady, age twenty-two; severe cold; no treatment, and convalesced in a week to ten days. But her younger sister, nineteen, began with similar attack. At the outset fifteen grains of salicin were given hourly for three hours, then fifteen grains every two hours; after eight powders, one hundred and twenty grains, cold entirely gone. *Case IV.*—Middle-aged lady; took six powders, ninety grains, and was relieved of severe coryza; it recurred the next day, but by evening yielded permanently to fifteen grains every two hours.

Acute Lumbago.—In two cases speedy relief has followed twenty-grain doses every two hours.

Hay Fever.—Two cases, treated with twenty-grain doses; symptoms were removed; has recurred when the drug was suspended.

E. D. H., Jr.

COHN ON THE PRODUCTION OF LOCAL ARTIFICIAL ANÆMIA AS A MEANS OF TREATING DISEASES IN THE EXTREMITIES.

(*London Medical Record*, December, 1877.)

Dr. Bernard Cohn relates his experience in treating three cases, (one of which was a white swelling of the knee,) of acute and chronic inflammation in the extremities, by temporarily rendering the limb bloodless with Esmarch's bandage:

An acute phlegmon of the toe, with inflammatory swelling of the foot, after fifteen minutes' application of the bandage, was followed by a very notable diminution of the swelling and pain. In a case of very painful diffuse swelling of the forearm, the pain, and the swelling, to some extent, disappeared. On these two cases the author properly lays less stress than upon the case of joint disease. A child of three and a-half years of age had suffered for eighteen months from a white swelling in the knee. The disease had originated in a fall, and a well marked acute stage had been followed by the characteristic chronic changes of tumor albus. The joint was swollen, painful, much flexed, and scarcely moveable, either actively or passively. It had been treated by fine gypsum bandages, covering twenty-six weeks. When Dr. Cohn first saw it, the affected knee was one and

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one-half inches larger than its mate, the bones felt thickened, the subcutaneous tissue infiltrated, and the borders of the patella were difficult to make out. No effusion of the joint was observed. The general condition was otherwise satisfactory.

The treatment was commenced by applying the bandage for a few moments only. But, after four or five days, it could be borne an hour daily—sometimes longer. Occasionally the application was made twice daily, when it was allowed to remain half to three-fourths of an hour each time. After three weeks it was found that the difference in the size of the two joints was reduced from four centimetres, (one and one-half inches,) down to half a centimetre. The condyles had become restored to their normal form, the patella loose and moveable, pain and tenderness had completely disappeared, the amount of passive motion was increased, and there was no pain on movement.

Forcible extension was now practiced under chloroform, and was attended by a recurrence of the inflammation; but this was rapidly subdued by the previous treatment. The final result was almost perfect cure; the patient could walk and move the joint in all directions without pain. The only trace of the previous disease which remained was a trifling amount of swelling, and a somewhat impaired mobility of the articulation.

Dr. Cohn states that the limb should be thoroughly emptied of blood, and the occlusion should be a perfect one. The final constriction should be made with several turns of the bandage and not with a narrow tube. In reply to a query, "How long can this bloodless state be maintained?" he says, The limit of safety is not likely, he thinks, ever to be reached, and we need not be anxious on this score, if the shutting out of the circulation be perfect. An imperfect occlusion is dangerous. The blood passes by the arteries into the limb, while the venous outlets are completely stopped. The pain is a great difficulty in this method, but it may be reduced by not applying the bandage constricting the limb above tighter than is absolutely necessary.

N. M. S.

ABOUT BOOKS.

A Guide to Therapeutics and Materia Medica. By Robert Farquharson, M. D., Etc. Enlarged and Adapted to the United States Pharmacopœia, by Frank Woodbury, M. D. Philadelphia: Henry C. Lea, 1877.

The design of the author of the work before us has been to present in a succinct and condensed form the present state of our knowledge, concerning the physiological and therapeutical actions of the various remedies now in ordinary use. We cannot say that he presents any

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new facts concerning medicines and their actions, but he is thoroughly impressed with the correct idea, that a proper and intelligent use of drugs depends upon an accurate knowledge of their physiological actions. The volume is another proof of the advance we are making in the right direction of throwing aside empiricism, and basing our therapeutics on a rational foundation, that of thoroughly appreciating the indications to be met in disease, and knowing the rationale of our means of meeting and counteracting them.

The feature of the work that is original, is the author's idea of placing the physiological action and therapeutical application side by side, opposite each other in double columns, thus showing clearly and at a glance how one depends upon the other. He takes care to give no points that are not pretty well determined and past the stage of discussion, and therefore what he says may be considered quite reliable and as representing the most advanced views at the present time.

The articles of the materia medica are not arranged in classified groups, as the author does not believe that this can be sufficiently accurately accomplished. So in order to waive the difficulties of physiological classification, he adopts the alphabetical system. We cannot entirely agree with him on this point. It is perfectly true that many medicines act in different ways and may be stimulating to some organs or functions while they are sedative to others, and so incapable of being brought under either head. Still, there are many well-defined groups, and it is perhaps carrying the principle a little too far to find fault with all classifications made on a physiological or therapeutic basis. A classification, such as that adopted by Wood or Bartholow, is quite scientific, and is a great aid to the understanding as well as to the memory. Under any circumstances, such a classification, though it may be faulty in some particulars, is by far preferable to the alphabetical system adopted in this instance.

In the introduction are some valuable remarks on prescribing, though we notice a tendency to give too great a prominence to *a priori* reasoning, and when this comes in conflict with well-known clinical experience, it must give way. This is very aptly pointed out by the editor of the American edition in a foot note, and he gives an illustration quite *a propos*.

Taking everything into consideration, we are very highly pleased with the work. It will be found a most valuable addition to the library of both student and practitioner. To the former, it will serve to give correct ideas in a compact form, and impress them strongly on his memory, and to the latter it will be useful to give him at a glance just what he wishes to know without robbing him of his time in having to read a number of pages to get a few important facts.

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THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY,

A Semi-Monthly Journal of Medicine and Surgery,

EDITED BY

EDWARD J. BERMINGHAM, M. D., and FREDERICK A. LYONS, M. D.

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LECTURES.

LECTURES ON PARALYSIS AND CONVULSIONS AS EFFECTS OF ORGANIC DISEASE OF THE BRAIN.

Delivered at Bellevue Hospital Medical College.

BY

C. E. BROWN-SEQUARD, M. D., ETC.

LECTURE VI.

GENTLEMEN—In the last lecture I pointed out to you the symptoms that are generally found when the paralysis occurs from disease in the cerebellum. To-day, I have to conclude with what relates to that question. You may remember that I said there was very frequently, in such cases, a disorder in the movements of the body. I characterized them as being similar to what is observed in a drunken man. One observer, taking into account the experiments of Ferrier, endeavored to show that the centres for the movements of the eyes are located in the cerebellum. He thought that if disease in the cerebellum produced disordered movement, it was due to lack of

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power in the eye. The movements of the eye become irregular and disordered, and a man who sees objects continually shaking before him, has disorder in his movements. This peculiar condition of disordered movements cannot be explained in this way. If it were due to such a cause, it would cease as soon as the eyes were closed, for then the impression of the shaking of objects would be lost, and consequently be without effect. In most cases there cannot be such an explanation, as there is no such pretended relation. These conclusions, as to the explanation of the disorder in movements, have been arrived at from Ferrier's experiments on the electrization of the cerebellum in animals.

Ferrier has not paid attention to a fact which always occurs in experiments of this kind. The movements seen in electrization are due to an irritation carried from the point to which the stimulus is applied. The action is caused in a reflex manner. The same sort of thing occurs when the sole of the foot is tickled. When we irritate that part, certain muscular movements occur in the face, but we do not conclude from that fact, that the centre for those movements is situated in the sole of the foot. The same reasoning leads us to deny that because galvanism of a certain portion of the cerebellum causes movements in the eyes, that the centre for their movements is situated there.

In order to establish the existence of a centre for special actions, we should be able to show that not only galvanism, but all other modes of irritation or excitation will produce the same action, and furthermore, when the brain is destroyed, or the part is taken away with a knife, we should get a cessation of the movements.

I have found in six or seven hundred cases of cerebellar disease no trouble whatever with the eye; only in a trifling number of cases is there trouble with the eye. Cases vary greatly, in some there is spasm of the recti muscles, in others there is something else, and there are a great many kinds of difficulty. It is certain, however, that a peculiar disorder of movements is frequently observed in disease of the cerebellum.

There are two other peculiar features observed as regards disorder of movements in disease of the cerebellum. These are just the opposite of each other, one being a tendency to run forward, and the other being a tendency to run backward. There are cases reported of tubercles situated in the centre of the cerebellum, in one of which the patient had a tendency to run forward, and in the other there was a tendency to run backward. Now you cannot in one individual locate in that spot the centre for forward movements, and in the other the centre for backward movements in the same place, and as, besides, in disease of the same part of the brain a variety of symptoms may occur, you cannot say that there exist centres for forward, or backward, or side movements.

So it is with the rotatory or circular movements. You can find all of these peculiar aberrations of movement in disease of other parts of

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the brain, although, it is true, some of them are found most frequently in disease of the cerebellum. The rotatory movement occurs more frequently in disease of the pons Varolii where the crus cerebelli enters it, or in the crus cerebri. These portions have more power of producing this movement than the cerebellum. Disease of the suprarenal capsule has been known to produce this description of movement. Disease of the auditory nerve, with or without organic disease of the brain, has been known to produce it, as in the celebrated case of the Duke of Wellington. He was suffering from some trouble with the ear, and a quack injected into it a solution of nitrate of silver. The next day he was seized with this affection and continued to roll round and round in his bed.

But to continue with what I have to say of the symptoms that coexist with disease in the cerebellum. There is a fact of considerable interest concerning the sexual organs. It has been said that the cerebellum is the centre for the sexual apparatus. It is certainly true that in some cases of disease we find a loss of sexual power, but we may, on the other hand, see exactly the reverse of this condition present. An inflammation in the centre of the cerebellum may cause either loss or increase of the sexual power. The conclusion that there is no relation between the sexual power and the cerebellum comes out even more clearly when you see that no change whatever may appear in this function when there is extensive disease of the cerebellum.

In one of the most remarkable cases that I know of, of disease of the cerebellum, that recorded by Dr. Combette, there was no trace of disorder of movements, or inability to stand or walk. In this case the disease was located in the cerebellum and its attachments. There was no loss of sexual appetite, but, on the other hand, an enormous increase. If the organ were in connection with, or had control of the sexual apparatus, something quite different should have occurred. The patient was a young girl who was intensely addicted to masturbation. The result was not due to an irritation of the organ, as there was no organ there to be irritated. We cannot say that the symptom was due to such a cause, as the cerebellum was completely absent. The views, then, as regards the presiding power of the cerebellum over the sexual apparatus cannot be entertained.

Another most important point relates to the paralysis itself. If the cerebellum has any particular function, it is the organ that serves for the production of nerve force. The only thing that is at all constant in disease of this organ is a diminution of the strength. This loss of strength exists in all parts of the body, whether the disease is situated in one-half or the other of the cerebellum, or in the middle.

The variety of paralyses that occur in disease of the cerebellum is extremely great. There is no doubt, however, that in most cases there is a localized paralysis. Paralysis may be due in some of these cases to pressure on the pons Varolii exerted by the lesion in the cerebellum. Almost invariably in these cases, the paralysis is on the opposite side of the body. We find such results particularly when

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the leison in the cerebellum is of such a nature as to cause pressure, as a hæmorrhage or a tumor of considerable size that presses on the pons Varolii. In such cases the paralysis is due in reality to disease of the pons Varolii, and only apparently to the disease in the cerebellum.

Sometimes paralytic symptoms appear in cases where there is but very limited disease in the cerebellum, as a slight softening. In such cases paralysis cannot be due to pressure on the pons Varolli, and there is no doubt whatever that paralysis may appear where there is no degree of pressure whatsoever.

There may be, in rare instances, paralysis of the face, or the tongue, or the whole body, but as a rule, in hemiplegia allied with disease of the cerebellum there is no paralysis of the tongue or of the face. In these facts lie the principal points of diagnosis. If a patient be suddenly struck down with apoplexy and has a strong hæmorrhage, if he have hemiplegia, difficulty in breathing, coma, and loss of consciousness, we have here the symptoms usually occurring in hæmorrhage in some part of the encephalon. If we find no paralysis of the face or tongue, and when the patient recovers from the first effects of the stroke he has vomiting, amaurosis, etc., we may usually consider that the hæmorrhage has occurred in the cerebellum. When the patient has recovered sufficiently to get up, and when he walks, we notice that besides his hemiplegia, he has disorder of the movements, we are still further led to think that the disease is situated in the cerebellum.

Professor Andral has pointed out perhaps more forcibly than any one else, that disease frequently coexists on one side of the brain, and on the other side of the cerebellum. In such cases the paralysis that occurs is almost always situated on the side of the body in which the disease located in the brain would produce it, viz., usually the opposite. This is almost always the case when there is a lesion on one side of the brain and the other side of the cerebellum. There is an exception sometimes when we find tubercles scattered on the right side of the brain and the left side of the cerebellum, and in some of these cases we have paralysis on the right side of the body, contrary to Andral's rule.

Another feature is extremely interesting. When atrophy is found consequent on disease of the brain, we almost always find some in the cerebellum on the opposite side. We shall have to pay more attention to this in the future than in the past, as much that will prove of interest will be found in this fact of connection.

Now let us pass to the crura cerebri, parts above the pons Varolii at the base of the brain. They are composed of a great nest of fibres going through them to enter into the corpora striata and optic thalami, or to go directly to the convolutions of the brain. This part certainly is full of interest. It is quite certain that the crus on each side is, according to the prevalent theory, the only bond establishing connection between the same side of the brain and the opposite side of the body. As every-

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thing is narrowed down, then, to one particular location, what pathology shows us in regard to disease of this portion is far more important than what relates to other parts. There is no possibility of escaping from the conclusions to be drawn from these facts. All the fibres serving for voluntary motion pass here, those from the right side of the brain in the right crus, and those from the left side of the brain in the left crus. This is in accordance with the generally admitted theories.

If these theories were right, when there is disease in a small part of the crus, striking only a few fibres of the many that compose it, say the outside fibres, the paralysis should be limited accordingly. If these fibres are really what they are imagined to be, going straight to the muscles after having passed through cells in the medulla oblongata and spinal cord, we should always see the paralysis limited entirely to certain muscles. It might be paralysis of the arm or leg, or only a few muscles of the arm or leg might be involved. Now such is not the case at all. There are a great many cases of disease located in the crus and having destroyed the fibres in different parts. A paralysis, if it exists, should be seen in those muscles receiving their nerves from the particular part of the crus that is the seat of the disease, and chiefly on the opposite side of the body. In by far the vast majority of cases the paralysis is more extensive than it ought to be, taking into consideration the extent of the lesion. You may find paralysis of one arm or of one leg only from disease in the crus cerebri, but do not therefore believe that any particular fibres are destroyed, as we may find the same paralysis of the arm alone when the disease is elsewhere in the crus, or even in the whole of the crus. There is no connection between the seat and extent of the paralysis and the location and limit of the lesion in the crus.

There are cases where there is no paralysis at all following disease in the crus cerebri, as in the case of abscess of Jackson of Boston. There are cases where the whole of the crus has been destroyed, and there has been a complete absence of marked paralysis. Still more, there are cases—four to my knowledge, one by Mason—in which disease in the crus cerebri produced paralysis on the corresponding side of the body. So that in this organ, as well as in other parts of the brain, we see facts that are entirely inconsistent with the old views. We see no paralysis where there ought to be paralysis, or we see paralysis where it ought not to exist, or we see paralysis on the wrong side of the body, although it ought always to be on the side of the body opposite to the side of the brain on which the lesion exists, according to the old theories.

There are five cases to my knowledge in which both crura cerebri were destroyed without giving rise to any marked paralysis.

From an examination of all these facts, you must be led to admit what I have already said, that very few fibres are necessary to establish the connection between the will power and the muscles.

The symptoms of disease in the crus cerebri are quite interesting to

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study. The third pair of nerves which moves a great many muscles of the eye is affected almost necessarily in disease of the crus cerebri, unless the disease is situated in the back part. Dilatation of the pupil results as a consequence of paralysis of the constrictor muscle. There is also strabismus, owing to the persistent action of the sixth pair of nerves. In a considerable number of cases there is diplopia. There is paralysis of the elevator of the eyelid which is innervated by a branch of the third pair, and so we have ptosis. So you generally find ptosis, strabismus, diplopia, dilatation of the pupil, etc., existing when the disease is situated in the crus cerebri, and these points will help you in the diagnosis.

If the disease is situated in the back part of the crus cerebri, the third nerve may escape, and then these symptoms will be wanting.

It has been supposed that the conductors of sensation, likewise, in going to the brain, pass through the crura cerebri. This idea is radically false, as they may be destroyed without any loss of sensation. In one case hyperæsthesia occurred.

There are some other features which may lead you to the diagnosis of disease in this place It is in the neighborhood of the passage of the fibres of the optic nerve, and so you may get derangement of vision. Where the tubercula quadrigemina are involved, you frequently see amaurosis. In three or four cases I have seen hemiopia. From these symptoms you may have means of diagnosis in many cases where the disease is in the crus cerebri on either one or the other side.

The tubercula quadrigemina are frequently injured when the disease is situated in the crus, and they have been considered as centres for vision. They have, certainly, a power over vision, but they both may be diseased without any amaurosis, or one may be diseased alone, and produce amaurosis in both eyes. There is then no necessary connection between them and the power of vision, but in the majority of cases we are able to say that when they are diseased we get certain changes in the power of vision. Fortunately, by a complete analysis of the symptoms occurring in brain disease, we can often come to a correct diagnosis.

Disorder of movements may exist when the tubercula quadrigemina are diseased, the same as occurs in disease of the cerebellum, but in this case the symptom is usually less marked. When the eyes are closed the patient cannot stand on one foot. We also find this condition present in disease of other parts, but most frequently it is due to disease here. This fact led Cocks, and other physiologists, lately to conclude that the tubercula quadrigemina were centres for the muscular sense. This is not so, as in many cases of disease of these organs there is no lack of the balancing power.

To pass now to other parts. There are two large ganglia, or rather part of one and the whole of another, that protrude into the lateral ventricles. One of these is the corpus striatum, which consists of two parts, the intra-ventricular and the extra-ventricular. They had always been considered as voluntary motor centres up to the time of

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the experiments of Fritsch and Hitzig, who have thrown physicians into the belief that the centres are located in the convolutions. Todd, Carpenter, and most others look on the corpora striata as voluntary motor centres, but here again I am obliged to dissent from these accepted views. I now speak of the intra-ventricular portion of the ganglion. Disease here, if the part were, as is believed, employed in moving the muscles, if it produced irritation, would cause convulsions to be manifested.

Now the truth is that irritation of no other part of the brain has so little power of producing convulsions. This is a decisive fact that shows that it is not a voluntary motor centre. It is said to be in connection with other parts, which, when excited, are supposed to give rise to convulsions. According to recent views, it has not been stripped of its power as a centre. It is supposed to be a place of passage for the voluntary motor fibres where they acquire new strength, being in connection with new cells which add fresh power to their functional activity.

In reality, we find cases of destruction of the corpus striatum without any paralysis at all, or at least without any marked paralysis. There is no relation as regards the duration, extent, and degree of the paralysis and the lesion in the corpus striatum from which it resulted. There are cases in which the disease was exceedingly slight and limited to a minute part of this portion of the brain, with, however, a persistent paralysis up to the time of death, and moreover of a severe character. The facts observed, are then in decided opposition to the theory.

Hughlings Jackson holds very properly, that one small part of this portion of the brain could alone perform the functions of the whole organ. He knew very well that a great portion of it could be destroyed, and that the function might yet remain, but when we find *all* of it destroyed, and still no paralysis or loss of function, why then there is an end to the theory.

Still more, we find disease occupying the intra-ventricular portions of both corpora striata without any paralysis. There is not one such case alone, but a great many like cases.

The corpora striata have no specific signs by means of which we can recognize the locality of the lesion, but we have some signs by which we can suspect its presence there. Hæmorrhage here is by far more frequent than in any other part of the brain, except perhaps in the optic thalami. There is also another exception to this generality, but perhaps it can hardly be called an exception, and that is, that it is also almost as frequent between these two ganglia, the corpora striata and the optic thalami. That peculiar condition that Charcot described as miliary aneurism is extremely common in the blood-vessels in this location, and this is the cause of the frequency of hæmorrhage in this location—that is, in the corpora striata and optic thalami, and between the two ganglia.

If you have paralysis of one side of the body, and symptoms of

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hæmorrhage in the brain, in this mere fact alone there is a supposition that the disease is situated in this region. Other symptoms of disease in the brain, such as paralysis of the third pair of nerves, the existence of amaurosis, symptoms in which the patient shows a tendency to go round and round, or forward, backward, or sideways, or execute particular movements, are by far less frequent when the disease is situated in the corpora striata, than they are when the disease is situated in other parts. Vomiting occurs less frequently in disease here. There may be hyperæsthesia in many instances. By passing in review all the symptoms known to be more frequent in disease of the base of the brain, and knowing that a lesion here is not so apt to produce these symptoms, we may most often come to the right conclusion, especially will this be the case if there are no convulsions.

This leads me to speak of the optic thalami, disease in which, will produce convulsions very frequently. It may also cause paralysis, and here again we come into conflict with the generally accepted views regarding the physiology of this organ. According to these theories it is not considered as assisting in voluntary movements, but paralysis comes on just as frequently from disease here as from disease in the corpus striatum or in other parts. These facts are highly in favor of the views I have given you, and decidedly against the view that paralysis arises from the destruction of centres or conductors.

In disease in the optic thalamus there is a great change in the reflex faculty in the limbs, when they are paralyzed, or even when they are not much or not at all paralyzed. It disappears entirely, or is much diminished, or just the contrary, there may be a condition in which the reflex faculty is increased.

There is still another feature of interest. There is often paralysis of the blood-vessels on the opposite side when the disease is situated in the optic thalamus. Not that I consider the optic thalamus as a centre for the vaso-motor system, but, nevertheless, the clinical fact exists. There is a dilatation of the blood-vessels, and a heightened temperature of the part. This is the reverse of what you usually find in disease of the pons Varolii, in which latter case, the limbs of the opposite side are found to be colder.

The optic thalamus is certainly a most interesting organ, and I wish I could dwell upon it more at length. There are few that are so extremely interesting. Very frequently, disease here is the cause of amaurosis. Still more, there may be loss of the senses on one side, generally on the opposite side, very similar to the conditon produced by division of the trigeminal nerve as described by Magendie. The loss of senses is slowly produced, generally on the opposite side, and it differs from division of the trigeminal in that respect.

What is more remarkable still, we have an alteration in the structures of the eye. This has occurred in two cases to my knowledge, and I dare say it has done so in more. In these cases, the trigeminal nerve was apparently healthy, so that there is, then, a great resem-

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blance between its properties and those of the optic thalamus. It has been considered as the centre of sensation, but many new observers have given up the views of Todd and Carpenter. In the neighborhood, but not inside of the optic thalamus, is the channel of passage of the fibres serving for the perception of sensation. These fibres go to the posterior lobes of the brain, but we very frequently find destruction of the posterior lobes without any anæsthesia.

We will pass now to another part of the brain, that is, the radiation of the fibres to the convolutions on the external surface. This part constitutes the centrum ovale. Disease in this portion of the cerebral lobes can produce paralysis, and the paralysis may be just as great as the paralysis produced by disease anywhere else in the brain, and there is this remarkable fact that the disease may be situated in the most distant and distinct parts and still give rise to the same kind of paralysis. Disease in the anterior, middle or posterior lobes can produce paralysis.

Disease in any part can produce complete paralysis on the opposite side of the body. If the disease here is limited in extent, can it be that all of the fibres are destroyed? Where the paralysis is complete and the casual lesion is limited, the facts cannot be reconciled. In such a case, the paralysis should be slight or local, but I repeat that complete persistent paralysis is often present.

In the cases of Porta and others, all of this portion of the brain has been destroyed without any paralysis at all.

There follows necessarily, also in the examination of these facts, a series of proofs against the views generally admitted. Paralysis or convulsions may be on the corresponding side to the lesion, or on the opposite, but in one out of every three hundred cases the paralysis will be on the same side. Not so, however, with convulsions. You will find them as frequently on one side as on the other when only the white fibres are diseased. Paralysis cannot then be owing to a destruction of fibres conducting the impulses from the will power to the muscles.

CLINICAL LECTURE.

Delivered at the College of Physicians and Surgeons, New York,
BY
T. GAILLARD THOMAS, M. D., ETC.,
Clinical Professor of Diseases of Women and Children in the College of Physicians and Surgeons New York.

I. LACERATION OF THE CERVIX UTERI. II. HEMORRHAGE AFTER ABORTION. III. PRURITUS VULVÆ.

GENTLEMEN—Of the cases I shall show you to-day you may, perhaps, have seen many examples before in this clinic; but this must not discourage you. You must always keep distinctly in mind what is the

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object of a clinic like this. You come here to make yourselves familiar with cases that you are likely to meet with in ordinary practice, and not with those that you may, perhaps, never be called upon to treat. I am sure that if I had been going to perform gastrotomy today every seat before me would have been filled, and naturally; but you come to see such operations as a sort of curiosity. The time of a clinic like this, however, should be occupied by the exhibition of such cases as you will often see in your office, and that you may be called upon any day to treat. It is true that your text-books tell you how to treat these cases, but only in a certain way. You are not brought face to face with the case, as you are in a clinical lecture, where the case and the treatment are so closely brought into apposition. I need, then, make no further apology for showing you a certain class of cases frequently.

The first patient is Mrs. Mary F., aet. 34, a native of the United States; married nine years. She has had three children and no miscarriages. The last child was born five years ago, and she has never been well since. Now, in hearing this history, there are two points that ought to make an impression on you at once. She has been married nine years, and has borne three children, all three of which were born in the first four years of married life; but, for the last five years, the greater portion of the time, she has been sterile. This is a curious fact, to say the least. The second point is this, that her last child was born five years ago; from that particular time she has never been well. The inference must be, that something occurred at her confinement to make her an invalid, and prevent her bearing any children afterward.

Up to that time she had been pretty well, suffering only occasionally from a little weakness. Now, let us inquire into what the trouble has been since that time. She says that for two or three days before the commencement of her menses she suffers from pain. Sometimes these pains are relieved when the flow is established, but sometimes they continue, though in a less degree, during the flow. She further complains of a constant backache, and a continual leucorrhœal discharge, of a slimy, yellowish substance. This discharge irritates the parts considerably.

The history is a short one, and the patient has but very few symptoms to be relieved. They are very clear, and she comes here to have them removed. Let us recapitulate them: *First*—Sterility of five years' duration. *Second*—Profuse leucorrhœa. *Third*—A fixed backache; and *Fourth*—A pain in the left side, coming on two or three days before menstruation, and very often relieved when the flow commences.

Now, let us see what an examination reveals to us. The finger touches the cervix, and, on rocking the uterus backward and forward between one hand in the vagina, and the other on the abdomen, it is found to be perfectly in its normal position. On placing the patient on her side, and introducing the speculum, the vagina is found to be

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bathed in a discharge, and is in a condition of chronic inflammation. The cervix is found to be lacerated extensively. It has contracted somewhat, as the injury is an old one; but I can almost pass my finger up to the os internum. I could not map out the left ovary distinctly, but, on pressing the broad ligament in the situation the ovary ought to occupy, it was found very sensitive to pressure. Clasping the ovary between the hands is not always practicable; but in this case it is highly probable that the pain produced by pressure is due to chronic ovaritis.

What accounts for the leucorrhœa? On the introduction of Sims' speculum, we saw what is commonly called a large granular ulcer. This condition is not, however, an ulcer; it is the cervix uteri which has been entirely laid open and exposed by the laceration. To this condition is due the leucorrhœa.

The fixed backache is likewise due to this cause. The exposed surface of the cervix is very tender, and in a neuralgic condition. It is in just the same state as the lower eyelid would be in a patient suffering from ectropion. It is a delicate part, and not intended to such exposure. Any irritation or inflammation produced pain in the exposed surface. The pain in the back is a reflex neuralgia transmitted to the spine. You often see the same thing in other parts of the body. The remains of an old tooth in the jaw often gives pain in the eye.

It now only remains to discover the cause of the fourth symptom. What is the sterility due to? The discharge is quite sufficient to destroy the function of the zoasperms. We not only find sterility in such a case as the present, where the cervix is lacerated, but even when there is only a slight inflammation in the cervical canal. The discharge in this case is of a very ichorous character, and is quite enough to cause the spermatozoa to lose their vitality. When the seminal fluid, taken from the vagina, is examined a short time after coition, it is found full of devitalized zoasperms.

Here, then, we have everything from which this patient suffers accounted for. Now as to the treatment, which, of course, is intended to relieve her symptoms. Let us begin with the first one, the leucorrhœa. How can we relieve it? Only in one way, and not by treating the condition of the cervix as a granular ulcer, not by the hot iron, nitrate of silver, nitric acid, etc., but simply by restoring the cervix to its original normal condition. The vaginitis and vulvitis may be let alone, as they are but secondary results of the ichorous character of the discharge from the cervix. Remove the cause of the trouble, and you cure it.

Now as to the sterility. The same answer applies here. It may be a long time before these symptoms are relieved, perhaps six months or more, but eventually they will all disappear, when their cause is removed. Now as regards the condition of the ovaries. The state in which they are at present, it is highly probable, is due to the traumatism, and is reflex in character. When the cervix is restored, the

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condition will probably be relieved, but if it is not, we may then try galvanism, counter-irritation, rest, etc.

I imagine some of you are already asking, would I not use vaginal injections? I would, but I would not rely on them. Suppose a dentist finds a tooth giving rise to supra-orbital neuralgia, he might certainly advise local applications, but if he acted intelligently, he would first remove the cause of the difficulty. He would treat the result afterwards. You may say that I am now talking as a lecturer, but let me say that I would speak to you in the same way in my office, in private. This woman will certainly get well if the lacerated cervix be attended to in the proper way. Unfortunately, we cannot operate here, and, in this woman's circumstances, it would not be advisable to do so at home, but she may go into the hospital, as we shall endeavor to persuade her, and there she shall be attended to.

Uterine Hæmorrhage after Abortion.

The next patient presents a condition similar in its *pathology* to the last one in some respects, though as you will see the *symptoms* are different.

Mrs. Hannah S., aged 40, native of Ireland, married twenty years. Has had ten children and one miscarriage. The miscarriage happened the last time she was pregnant, which was three months ago. Her confinements have all been pretty easy labors except the last one, which was about three years ago. She has been sick for the last three months, in other words, since her miscarriage. She complains chiefly of flooding. She also says that occasionally something seems to loosen in her throat, and then falls down. This is probably one of those obscure reflex nervous troubles that are so frequently seen in uterine disease. She likewise complains of great weakness, and is afraid to do any housework for fear her strength will give way. She could attend properly to her work before three months ago, but since that time she has flooded continually, and has lost considerable blood. If you look at her face, you see how pale and weak she looks, and you see right away that she must have lost a quantity of blood. The pulse is weak and rapid.

Now, gentlemen, you have heard her history. The tenth labor, three years ago, was the hardest of all. Three months ago she had a miscarriage and has been an invalid ever since. She has lost blood, not only at her menstrual periods, but all through the month.

Examination shows that the perineum is ruptured all the way down to the sphincter ani. The vagina is long and flabby, and there is slight rectocele. There is a large sub-involuted vagina which has grown lax and feeble from many parturitions, and the injury inflicted on the perineal body. Here is a woman who, according to her own story, has been well and suffered no inconvenience for three years, for at least it must date from her last labor, with this condition of the perineal body, while the cervix uteri is in the same condition as it was in the patient who has just gone out. She has never had violent

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leucorrhœa, and yet she has the same condition of things that produced it in the previous case. Here also, the uterus is in a condition of complete subinvolution. What was the cause of this? Perhaps it was not the laceration, for it did not cause it before the miscarriage took place. She has then, laceration of the cervix, subinvolution of the uterus, subinvolution of the vagina, and rupture of the perineal body, four conditions closely connected with each other, but yet she has not suffered near so much in comparison to the pathological state of her organs as the previous patient. Here is a contrast which often occurs, and it teaches an important lesson. In gynecology do not look for mere pathological facts, but for pathological conditions which give rise to symptoms from which the patient suffers. You may find a fibroid tumor in the uterus, but it may occasion no inconvenience and have nothing to do with the symptoms for which a patient seeks relief, though it may be curious and interesting as a pathological fact.

But let us return to our case. This laceration, although it certainly exists, has not much relation to this woman's symptoms, and it is not the trouble for which she seeks our aid. Its cure will not, perhaps, relieve the other, and at present more important conditions. In this case let the cervix alone. Sew it up and do nothing more, and she will be just as bad as she was before. The hæmorrhage, which is her real trouble, may still continue, and she will have a just right to say that you have done her no good.

The woman comes to be relieved of certain symptoms which she has related to you, and your duty is to find out what is the cause of the hæmorrhage. The condition of the cervix is not causing it, as that has been there at least three years. The rupture of the perineum has nothing to do with it. The subinvolution of the vagina may likewise be excluded. It must have been something that occurred at her miscarriage. This is in all probability some alteration in the mucous lining of the uterus. In such cases it may be necessary to dilate the cervix with a sponge tent and examine the uterus, but do not use the sponge tent unless you are forced to do so. It is a decidedly dangerous method of proceeding. Some years ago I used to use the sponge tent very frequently, and would speak of them carelessly and flippantly, regardiug their use as a matter of little moment, but since then I have seen too many cases of cellulitis, too many cases of death following their use to talk about them flippantly now. Of course I have not entirely discarded their use; I employ them when necessary, but I recognize their danger, and am cautious.

The cause of this hæmorrhage might be a piece of placenta still remaining in the uterus, it might be no larger than the smallest joint of one of the fingers. About six weeks ago, a patient came from Highland Falls to consult me, and complained of a hæmorrhage after a miscarriage. I sent her home for the time being, gave her some ergot to take and told her to come back. She did not do so, but at the end of about a week sent me a piece of placenta which had been cast out by means of the ergot, and the hæmorrhage was cured. Such a

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cause might be at work here, and if so it might be necessary to employ the sponge tent.

The most common cause of such a hæmorrhage, however, and I speak, having in mind the results of a long experience, is a fungous growth in the mucous membrane of the uterus. So the first thing you should do is to take a copper wire curette by which you can scrape out the cavity of the uterus, but you can never do any injury to it. This instrument is entirely harmless, as it bends on the slightest pressure. In this case I used it, and said to my assistant at the time, that if we found nothing, we should have to use the sponge tent.

Here you see the result of the operation and the cause of the hæmorrhage. Here are a number of fungoid growths, that we scraped out of the uterus. They are hypertrophic elongations of the lining membrane of the uterus, little polypi. It may be that if they were left in situ, they would become true polypi, but of this I have no proof. Now, if I get all of these growths out of her uterus, the hæmorrhage will be entirely relieved.

How about the perineum and cervix. Well, we may cure them, but why should we operate if she does not suffer from them? Suppose all these fungoid growths are removed, she will get entirely rid of her hæmorrhage and will soon recuperate and regain her health and strength. She thinks she would be entirely well if this hæmorrhage were stopped. The thought comes into your mind how much better she would be if perineum and cervix were restored, but remember that it was not on their account that she sought relief, but if after all she thinks their restoration would benefit her, then you may attend to them.

Pruritus Vulvæ.

The next case that I shall show you is one of very long standing, and also one that is very commonly met with, yet the more books and authorities you consult in regard to it, the worse off you will generally be, there are so many divergent opinions concerning its pathology, and so many different ideas as regards it treatment.

Mrs. M. C., aet. 50, native of Ireland, married 26 years, has had seven children and one abortion. The last child was born seven years ago. She says she has been sick for twenty-six years, so I think we are right in calling the case a chronic one. She has but one symptom and that is an excessive itching of the vulva. This pruritus vulvæ is so bad that it is the bane of her existence, and if you cannot give relief, and very frequently you cannot, you can see what a terrible bane it is. The itching is sometimes so bad that it keeps her awake for hours at night, and she is obliged to scratch herself almost all the time. She passed the change of life, or, as we call it, reached the meno-pause a year ago, but this made no difference in the condition of the parts. She has been much worse at various times than she is at present. She says she has no itching in other parts of her body.

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Now let me tell you what an examination showed us. The patient being placed upon the back, the finger placed in the vulva. The labia majora were found to possess exquisite sensibility, the slightest touch giving pain. The finger being carried into the vagina, a free leucorrhœal discharge is found. The uterus has undergone physiological atrophy at the meno-pause, but the cervix is found uncommonly large, and when the speculum is introduced it is found to be the seat of intense inflammation, and the vagina likewise is in a similar condition. All the parts around the vulva are almost in a condition of eczema, the surface is so intensely red. The constant scratching with the nails has tended greatly to aggravate this condition. Now what is the cause of this pruritus, for that is what we must seek for; the pruritus being only a symptom produced by some cause that we must find out, if we can.

Some years ago a woman came here almost wild from loss of sleep and opium eating. The parts were terribly excoriated with the nails, and were in a fearful condition. In her case, I ran over all the causes and could not fix on any of them, and finally thought of diabetes. I obtained some of her urine and had it examined, and it was found to contain sugar.

I simply mention this case to tell you and to impress upon you the fact, that you must always look for a specific cause. If you look at your books and glance over the number of prescriptions given for this symptom, and perhaps choose one of them, such as biborate of soda, or bichloride of mercury, and order it to be applied, you will have done just nothing at all for your patient in most cases. Sometimes by looking at once for the cause, you can cure a case instantly that has lasted for months.

Sometimes in looking carefully, you may find pediculi in patients in whom you would least suspect them. In such a case a single application would be sufficient to relieve the patient. In many cases the pruritus is continually aggravated by the constant scratching with the nails.

I simply wish to call your attention to the absolute necessity of discovering a cause for this distressing malady.

Another cause that is not so frequent as those I have mentioned is true eczema. If this be the condition giving rise to it, do not treat the pruritus, but the eczema itself. Give arsenic, recommend proper diet and hygienic habits, keep the skin in constant activity, and the symptom will disappear, but under no local applications would it be cured. Other skin diseases may likewise be the cause, but if so, treat them and not the pruritus.

The most frequent of all causes is vaginal leucorrhœa, and there is a peculiar kind of vaginal leucorrhœa that is extremely liable to cause it. The discharge in such cases is extremely ichorous and irritating. I do not know the true cause of this peculiar quality, but it is so marked that sometimes even on your finger it will cause irritation, and it often requires considerable washing to prevent this irritation. On

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coition this discharge may give rise to gonorrhœa in the male. A true urethritis may be set up, which, however, is not usually so bad as a specific gonorrhœa as shown in the comparative ease with which it yields to treatment.

Sometimes this leucorrhœa is but slight in amount, but still it is extremely irritating. It is amply sufficient to cause irritation and excoriation of the vulva as I have often proved to my satisfaction. If you wish to test the truth of this, simply tampon the vagina thoroughly for a short time and the patient will get relief. The discharge is thus dammed up and cannot come in contact with the parts to excoriate them.

What is the pathology of this case? The eczema of the vulva and thighs is due to this woman's nails. The constant scratching here, kept up for twenty-six years, accounts for it easily enough.

Now as to the treatment. Tamponning the vagina will not cure the case, and local applications will not do it for the simple reason that none of these means will stop the cause. The cause of this leucorrhœa must be removed, and this is a difficult thing to do. It may be impossible to cure it, but, at any rate, we can give some relief. I suspect there may be a polypus in this cervix, because it is so large, there may not be, however, and there may only be an inflammation.

We will give her biborate of soda as a vaginal injection, and once or twice a week we will expose the cervix, clean it thoroughly and touch it with a strong solution of nitrate of silver, or nitric acid, in the hope of changing the character of the inflammation. Then we will use a vaginal injection, and push up a large suppository containing five grains of gallic or tannic acid. This will prevent the free flow of ichorous mucus from the cervix and vagina. When this much is done for the cause of the trouble, then we may treat its results. These may be removed by your local applications outside, whatever one you give preference to, whether it be biborate of soda, or bichloride of mercury, or any of the others, it matters not which.

ORIGINAL ARTICLES.

REMARKS ON HYSTERIA.*

BY

FRANK P. FOSTER, M. D.,

Physician for Diseases of Women to the Out-Patient Department of the New York Hospital.

MR. PRESIDENT AND GENTLEMEN—The sketchy and disjointed character which you will remark in what I have to say is to be attributed to its hasty preparation—hasty from my having consented, at short notice, to supply a deficiency in the series of papers for our meetings.

* Read before the Medical Journal Association, December 21, 1877.

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In regard to the symptoms of the disease, nothing need be said of the convulsive form, for it is sharply enough defined and well described by a great number of writers. As to the other manifestations, however, my own observation leads me to think that well-marked globus is less frequent than would be inferred from most descriptions of the disease, whilst the reverse is the case with regard to pain and syncopal attacks. The pain to which I refer is well known as being more commonly situated in the back, (with tenderness over the lumbar, sacral, and coccygeal vertebræ,) in the hypogastrium, in one or both iliac regions, particularly the left, in the left infra-mammary region, in the epigastrium, in the occiput and nuclea, and in the neighborhood of the sacro-iliac synchondrosis of one or the other side—the frequency of its occurrence in these various localities following the order in which they are here enumerated.

In maintaining the frequency of syncopal attacks, I do not refer to seizures of well-marked syncope, although these are common enough in hysterical subjects, but to attacks of what may be called abortive syncope. The phenomena may be described as follows: The patient suddenly feels a horrible sense of impending unconsciousness, but full loss of consciousness never takes place. If standing or walking, she (or he, for this manifestation is almost equally common in the two sexes,) always feels as if she were about to reel and fall, (not to fall suddenly,) and frequently seizes some object, as a chair or railing, to support herself. Sometimes she actually falls, but she is always able to break the force of her fall by voluntary efforts and to call intelligibly for help. By an intense exertion of the will many patients are able to overcome the disposition to fall, and to conceal their apprehension of falling, but they cannot in the slightest degree avert the other phenomena of the seizure, although they may sometimes shorten their duration by a rapid succession of deep inspirations. These other phenomena are, a sudden pallor of the face, occurring at the onset of the attack, followed instantaneously by flushing of several minutes' duration; and, at the same time, a feeling as if the heart were about to stop beating, which also is only momentary and is followed by increased strength, but not usually by acceleration of the cardiac pulsations. These are the unvarying phenomena, but occasionally certain additional ones take place, such as choreiform twitchings of the muscles of the face or the upper limbs, always feeble, scarcely attracting the notice of a looker-on, and never tonic spasms. Exceptionally the seizure is preceded by an aura, generally referred to the hypogastrium. Many of these patients are more liable to be attacked when present at an assemblage of people, (notably at church, and more particularly upon changing from the kneeling to the standing posture,) and I am inclined to think that the dread of an attack under such circumstances is a powerful agent in determining its occurrence. A few are generally attacked soon after retiring to bed, but in such the seizure may always be prevented by the use of a moderate alcoholic drink.

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The pathology of hysteria has been the subject of no little dispute. On the one side are ranged those who, whether trammeled by the etymology of the word and the fanciful traditions which have come down to us from remote antiquity, or by that over-wheening absorption in a specialty which, even in this nineteenth century, leads men to repeat the old dictum, "*propter uterum est mulier quod est*," see in hysteria nothing but a train of symptoms directly dependent upon some disease of the genital organs. On the other side we find the strict neurologists, who, in my opinion, err just as widely in looking upon hysteria as an essential neurosis entirely independent of disease elsewhere than in the nervous system, and whose speculations as to aberrations of nervous force, etc., are little less grotesque than the ancient idea that the uterus was capable, in its autonomy, of retiring from the pelvis in disgust, and betaking itself to the gullet, there to tease and vex its unfortunate owner. It seems to me that the truth lies between the gynæcologists and the neurologists. I do not think that a brief and at the same time satisfactory definition of hysteria can be given, but I think that we may say that hysteria is an abnormal condition of the nervous system, in one or more of its parts, either inherited or acquired; that the reason of its manifesting itself almost exclusively in the female, is that its tendencies are more in consonance with the natural workings of the womanly than with those of the virile organism, and that therefore it meets in the former with less physiological (and in many instances with less volitional) resistance than in the latter; that it thus constitutes a latent predisposition to the phenomena which we recognize as hysterical—which phenomena may be evoked by emotional disturbances or by mal-nutrition, rarely, however, unless aided by positive physical disease in some part of the body, generally within the pelvis or the abdomen—notably the former. Such disease may be of little moment in itself. Indeed, my observation leads me to agree with those who state that hysteria is more apt to be developed by the slighter than by the severer diseases of the abdominal and pelvic contents—or rather, I would say, by those affections which, while they may ultimately prove serious, are for the time being giving rise to little, if any, local manifestation of trouble. Such disease may be nothing more than functional, for I have seen well-marked hysterical symptoms subside at once, never to re-appear, upon relieving a distended colon.

As to the element of perversity, I believe that it exists much more rarely than many physicians seem to think. True, many of the manifestations of hysteria may be more or less controlled by an exertion of will on the part of the patient, but such exertion must be extraordinary in degree, such as we have no right to expect from an enfeebled and long-suffering woman. Under the influence of some unusual stimulus, such as the dread inspired by the mention of some barbarous method of treatment, the patient may make such an extraordinary exertion of will, with the effect of overcoming the symptoms; and she is rewarded with the insinuation that she has been

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a maligner! Do we not all know that a drunken man may often be sobered at once by a profound and startling impression upon his mind? Are we, therefore, justified in assuming that his drunkenness was feigned? Great harm has been done by the undue stress which has been laid upon the power of the will to control hysterical symptoms, whereby the laity have imbibed the idea that to be hysterical involves a certain amount of culpability. The consequence is, that we are often debarred from giving to a woman who, far from wishing to magnify and prolong her ailments, is exceedingly anxious to be rid of symptoms which seem to her the harbingers of some dreadful brain disease, that consolation and encouragement which she ought to draw from the information that her malady is nothing more serious than hysteria; for, no sooner is this announcement made than she looks upon herself as being accused of a sort of fraud, and, being well aware of the groundlessness of such a charge, naturally feels hurt and seeks other advice.

In the treatment of hysteria, I regard it as of the first importance that the patient should be informed of the nature of the ailment, care being taken to disabuse her of the notion that any stigma attaches to the disease. We should not make light of her actual sufferings, but only of her gloomy forebodings. Careful search should be made for disease of any organ. As I have already stated, it will generally be found within the pelvis, and it should be made the subject of treatment, for, if neglected, it will seriously interfere with the effects of measures addressed to the nervous system, and moreover, in itself it demands attention, for diseases of the uterus show little or no tendency towards spontaneous recovery, but rather incline to become obstinate and serious. How absurd and hazardous is it to disregard the condition of the pelvic contents, and order exercise, on horseback, perhaps, when, at every step, an engorged uterus is dangling from a thickened broad ligament, and liable at any time to occasion an hæmatocele or some other serious accident.

Together with appropriate treatment of any local disease which may be discovered, the patient's general nutrition should claim careful attention. Hysteria has been looked upon as the result of luxurious living. The fact is, however, that it is more prevalent among the poor than among the rich. Far from reducing the diet, I think it is best to encourage the liberal use of the most nutritious food, provided it be easily digested, well assimilated, and the waste products of its metamorphosis duly voided. Alcohol, preferably in the form of spirit, is generally beneficial at one period, or another in the course of the affection, care being taken that the single doses shall not be large enough to produce flushing, headache, or other manifest effect. Cod-liver oil is also of great service. As regards drugs, I consider arsenic as altogether the most serviceable of those that I have used, but I confess that their number is few. For overcoming pain, it seems to me that electricity is the most useful measure, and I have found the galvanic current more efficient than the faradaic. In the

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few instances of hysterical convulsions in which I have employed pressure over the ovaries, I have not observed any effect from the proceeding.

As to the question of marriage, discussed by so many writers, I have never advised that measure, and I think that the cases must be exceedingly few in which such advice would be judicious. If there be disease of the uterus or its appendages, it is likely to be aggravated by marriage, and as to any benefit likely to be derived from gratification of the sexual desire, I wish to record my decided conviction that women, with very rare exceptions, are not much troubled with desire for sexual connection.

HOSPITAL RECORDS.

ROOSEVELT HOSPITAL, NEW YORK.

Reported by W. B. Berry, M. D., House Surgeon.

LIGATION OF THE FEMORAL ARTERY FOR FEMORAL ANEURISM—LISTER'S ANTISEPTIC METHOD—SERVICE OF DR. T. M. MARKOE.

John Murphy, Ireland, aet. 30, married, tailor. Patient states that sixteen years ago he first noticed a small pulsating swelling, size of walnut, on his right thigh. He locates it as then existing at upper limit of the patella, about two inches above the internal condyle of the femur. He says that while following his trade he continually used a heavy tailor's iron, which he rested on the lower end of his right thigh. He gives no other traumatic cause for the tumor. The swelling gradually grew larger, till two months ago, when it rapidly increased in size and became painful.

For last two weeks pain has been severe, and he has been unable to walk but a short distance, the power of using the limb suddenly giving out and compelling him to stop and rest. Family history good, and denies syphilis. On admission, there is well-marked pulsating tumor on anterior surface of lower end of right thigh. Its centre is just below a point over Hunter's canal, and is evidently an aneurism of femoral artery at this point. It extends well downward toward knee, pushing the patella down and outward. The tumor is well described seventeen and one-quarter inches in circumference, including the thigh, and about six inches in length. It is rather soft; ceases to pulsate on pressure on the femoral artery above, and in this condition can be much reduced in size by pressure.

There is a well-marked bruit over the tumor, extending up toward the artery.

There is no œdema of leg below, but the superficial veins are enlarged. Pulsation in both anterior and posterior tibial arteries is

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normal; *urine negative*. *Treatment*—Rest maintained in bed and patient put on liberal and nourishing diet.

October 19.—General health and tone improving. Size of tumor, (seventeen inches,) slightly diminished.

October 25.—Digital compression of femoral artery at Poupart's ligament and on inside thigh attempted, and after an hour's trial it was impossible to control the circulation, the arterial tension being so great. The attempt was given up, but the tumor became firmer and pulsated less. Size, same.

October 28.—Esmarch's bandage was put on from the toes over the tumor, well up on the thigh. The bandage was left on one-half hour and then removed, but circulation was stopped for one and one-half hours longer by the rubber cord, the patient being under ether. At the end of this time pulsation was decidedly less in the tumor, which was firmer.

October 29.—Pulsation in tumor about same as before. Esmarch's was applied. Tumor is firmer. Size, sixteen and one-half inches.

October 30, 3 p. m.—Patient under ether. Ligation of femoral artery in Scarpa's triangle performed by Dr. Markoe, assisted by Dr. Sands: An incision three inches long was made over the sartorius muscle on inner side of the thigh. The skin, fat and connective tissue were at once cut through, exposing the sartorius muscle covered by its sheath with its fibres running diagonally across the thigh at the upper third. Its sheath was opened, the muscular fibres pushed aside, and the connective tissue on its posterior surface carefully cut through. The femoral artery then came into view, and could be felt and seen pulsating, being of large size. The sheath of the artery was then opened, with the back of the scalpel toward the vessel. The aneurism needle was then forced around the artery from within outward, and the carbolized gut ligature tied. In tying the ligature, only sufficient force was used to stop the circulation, but not enough to break the inner coats. Catgut sutures were used, the wound covered by the protective, and Lister's dressings applied.

The operation was done under carbolized spray and with all Lister's precautions; 6 p. m., pulse, 100, Temperature, 104°. Given hypodermic Magendie, eight minims.

October 31, 9 a. m.—Pulse 84, Temperature, 98¾°. Patient passed a comfortable night. Seems in very good condition. Wound was redressed. Slight serous discharge. Looking very quietly, indeed.

November 1.—Feeling "first-rate." Pulse and temperature about normal.

November 2.—Circulation in the leg very good. There is no œdema nor recurrent pulsation in the tumor. The aneurism sac feels firm, and size of tumor sixteen and one-quarter inches.

November 3.—Redressed. There is primary union along the whole face of wound. Discharge inconsiderable. Sutures left in. Patient with appetite good and in best of spirits.

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November 5.—Complains of no pain. Size of tumor sixteen and one-eighth inches.

November 6.—Redressed. Gut sutures all softened off. Looking very quiet. Primary union seems firm. Lister renewed.

November 8.—Lister's dressing discontinued. Union perfect; cicatrix dressed with sheet lint and strap. There appears to be slight recurrent pulsation in the tumor, (nine days after ligation;) size same, sixteen and one-eight inches.

November 10.—Pulsation in the tumor more marked, but slight as compared to that before ligation. There is no pulsation in femoral below the seat of ligation.

November 13.—Size of tumor, fifteen and one-half inches.

November 16.—A flat bag of shot of ten pounds placed over the tumor, with ice bag applied to the shot.

November 17.—Pulsation slight. Size, fourteen and three-fourth inches.

November 26.—Pulsation still slight; size, about same, fifteen and one-eighth inches.

December 1.—Size same. Pulsation has ceased.

December 7.—Discharged; cured.

EDITORIAL.

HEALTH OFFICER OF THE PORT.

This important office has virtually been vacant since the spring of 1875, when Dr. Vanderpoel's term expired. Ex-Governor Tilden at that time nominated Dr. Austin Flint, Jr., to fill the position, but on account of difficulties between the Governor and Senate, the latter declined to confirm the nomination. The governor failed to submit another name for approval, and consequently Dr. Vanderpoel continued in office until the inauguration of Governor Robinson. It was now hoped by the leaders of both political parties that the newly elected governor would settle the matter amicably, by presenting to the Senate the name of a person which it would confirm, but Mr. Robinson thought proper to submit the name which had been sent back to Gov. Tilden two years previously. There being every reason to believe, however, that the Senate would not confirm the nomination, Dr. Flint's name was withdrawn before it was acted upon. It was, however, sent a second time to the Senate by Gov. Robinson, who has again withdrawn it. So the matter rests to the present day, Dr. Vanderpoel filling the office until a successor shall be appointed.

As there is at present no probability that the Senate will confirm the nomination of Dr. Flint, many names are being urged upon the notice of Gov. Robinson, and it is to be hoped that he will present the most suitable one for confirmation at an early day.

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In the choice of a candidate, the Governor should not be expected to rely upon his own knowledge of the medical profession, nor upon that of his cabinet, to decide upon the person best fitted to fill this important position, and we take it to be the duty of the profession, and medical press, to assist him in determining upon the abilities of those that may be urged for nomination.

The following names are rumored as being strongly pressed upon the Governor's notice at present: Dr. Austin Flint, Jr., of New York; Dr. Paine, of New York; Dr. Horatio Robinson, Jr., of Auburn; Dr. Wilder, of New York; Dr. Alex. Hutchins, of Brooklyn; Dr. Frank H. Hamilton, of New York; Dr. Wey, of Elmira; Dr. W. A. Hammond, of New York; and Dr. Jones, of Albany.

We fear that Mr. Robinson will fall into a very grievous error, if the rumor be true that he intends to nominate Dr. Paine, of this city, a homeopath, and for many years the family physician of the Governor. We commend the Governor's gratitude and friendship, but in filling such an important office as that of Health Officer of the Port of New York, friendships should not be considered. What the citizens want is to have the office speedily filled by a thoroughly capable and experienced man. If the Governor nominates for the office an unknown member of a school founded upon an exclusive dogma, he will just as certainly have the name of the candidate returned to him. To substantiate our statement, let him investigate the fate of the bills that have been presented to the legislature by the homœpathic school. Almost all of them have been defeated by the members of the scientific school of medicine. It is not our purpose here to discuss the justice or injustice of this course, we merely wish to point out the fact, in order that the Governor may take advantage of it. Our remarks apply with equal force to Dr. Horatio Robinson, Jr., of Auburn, a homeopath; and with still greater force to the name of Dr. Alex. Wilder, of this city, who is classed as an "irregular."

Of Dr. Hutchins and Dr. Jones we have little to say. They are unknown outside their own immediate circles, and although either of them might be able to fill the position satisfactorily, neither the profession nor the laity have ever had any evidence of their ability. Besides this Dr. Hutchins is a member of the Democratic party and we do not think the Governor would risk his name, suddenly brought from obscurity before a Republican Senate.

Dr. Wey, formerly Mr. Robinson's family physician, is, we believe, also a candidate for the nomination. He is undoubtedly a man of some ability, but he cannot bring with him that long experience in sanitary matters that such men as Hammond, Hamilton and Flint, can. We think, therefore, that Dr. Wey will have to retire to guard against being obscured by the greater lights.

We are now narrowed down to Drs. Hammond, Flint, and Hamilton, whose names, it is rumored, are at present very strongly urged. We doubt whether Dr. Hammond would consent to his name going before the Senate, and are quite certain that it would not be confirmed

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should it be sent there; and as regards Dr. Flint's fitness for the position we have not the slightest doubt. Thoroughly scientific, with an amount of energy and executive ability seldom seen in a profession like our own, we feel sure that, if Dr. Flint's name were confirmed, he would not fail to discharge the duties of the office to the entire satisfaction of the State. But it is now well-known that the Senate is not inclined to look favorably upon his nomination, and it consequently becomes necessary for the Governor to submit another name, and of those reported as having been brought to his notice, none is more worthy the honor than that of Prof. Frank H. Hamilton, of this city. This gentleman is too well-known, not only in this country, but throughout the civilized world, for us to call attention to his fitness for the position. Few men have devoted a life to their profession and humanity as wholly as he has. As an author, military and civil surgeon, and teacher, the profession has long since accorded him the highest rank. As a sanitarian we believe Dr. Hamilton has few equals, and no superior. His work upon "Military Surgery and Hygiene" gives evidence throughout of his keen observation of the causes of ill-health among the troops, and the paramount utility of the measures he adopted to bring about a reform. His experience as medical inspector during the war of the rebellion, and the reputation he then achieved as a sanitarian, resulted in the Commissioners of Public Charities and Correction of New York choosing him, during the cholera epidemic of 1866, as Chairman of the Committee of Medical Inspection. The manner in which he fulfilled the duties of this office is best shown by the following extract from the report of the Commissioners to the Legislature. In speaking of the cholera, they say, (*vide Seventh Annual Report, page 15,*) "And in this connection it is proper to advert to the invaluable services of Dr. Frank H. Hamilton. When the cholera broke out, isolated hospitals were at his instance and under his directions established, a code of sanitary regulations formed by him was adopted, and radical changes in diet, and in the forms and hours of labor, at his suggestion, were made. To his resolute and intelligent action may be attributed the arrest of the disease, and so confident was he of the efficacy of his proposed treatment, that he foretold the number of days in which the disease would disappear. The last case occurred within twenty-four hours of the period he had designated."

In addition to these facts, we may call attention to his efforts at reform in sanitary matters in this city, during the past two years, which have shown still further his clear views in regard to these matters, and an indomitable perseverance in carrying out his ideas.

If Gov. Robinson would consult both the wishes of the medical profession and laity, he would nominate Dr. Hamilton, as the most suitable of those who have been brought to his notice, and in our opinion the most capable person to fulfill the duties of the office. In addition to carrying out the wishes of the citizens in this matter, the

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Governor would meet with no opposition from the Senate on party questions, the doctor being a Republican.

We sincerely hope that this matter will be amicably settled before long, and that the Governor will see fit to make a nomination which will adjust the difficulties existing between himself and the Senate, and at the same time give entire satisfaction to the citizens of the State.

PERISCOPE.

COLLABORATORS.

Dermatology.—HENRY G. PIFFARD, M. D., Professor of Dermatology in the University of New York.
Diseases of the Nervous System.—EDWARD C. SEGUIN, M. D., Professor of Diseases of the Nervous System in the College of Physicians and Surgeons, New York.
Diseases of Women and Children.—FRANK P. FOSTER, M. D., Gynecologist to the Out-Patient Department, New York Hospital.
General Surgery.—EDWARD J. BERMINGHAM, M. D., Surgeon to the Good Samaritan Hospital for Diseases of the Rectum, and to the Out-Patient Department, Bellevue Hospital, New York.
Genito-Urinary Diseases and Syphilis.—ROBERT W. TAYLOR, M. D., Professor of Dermatology in the University of Vermont.
Ophthalmology and Otology.—S. B. ST. JOHN, M. D., Assistant Surgeon to the New York Eye and Ear Infirmary.
Orthopedic Surgery.—NEWTON M. SHAFFER, M. D., Surgeon to the New York Orthopedic Dispensary and Hospital.
Practical Medicine.—E. DARWIN HUDSON, JR., M. D., Professor of Practice of Medicine, Woman's Medical College, New York.

RELATIONS OF OPHTHALMOLOGY TO GENERAL MEDICINE.

J. Hughlings Jackson, in his annual oration before the Medical Society of London, discusses at some length the Relations of Ophthalmology to General Medicine, noting the importance of discovering errors of refraction, and mentioning a case coming to Brudenell Carter with supposed cerebral disease, which was found to be simple myopia. In this case, the patient came to Mr. Carter, not on account of trouble with his eyes, but because he had heard that ophthalmic surgeons had an instrument useful in investigating brain disease. He instances also the case of a medical student affected with persistent vomiting and frontal headache; vision good, both for near and distant work, but hypermetropia and astigmatism existed, and when suitable glasses were supplied, the vomiting and headache stopped, and he resumed work after two years enforced idleness. Dr. Jackson thinks the evidences of neuritis from strain on the ciliary muscle in hypermetropia throw light on cases in which functional abuse leads to paralysis, as in writer's cramp, or in congestion and œdema of the brain from overwork. There is danger too, of mistaking for cerebral disease the giddiness, irregularity of gait and confusion of sight, arising from slight paresis of ocular muscles. This vertigo is not from diplopia, as so commonly supposed, but from false estimates of the

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position of objects by the affected eye; the position being judged of by the amount of nerve force exerted to bring the eye to bear on the object. If the object be upon the same side with the weak muscle, an unusual amount of nerve force must be employed to turn the eye toward it, and the brain, judging by the old standard, conceives the object to be much further removed from the median line, (in case of the paralysis of the external rectus,) than it really is. This vertigo is, physically considered, a *motor* symptom, not *sensory* as is commonly supposed. Also from what is called secondary deviation in paralytic strabismus, *i. e.*, over-action of one muscle when its paralyzed congener is sought to be brought into action, may be deduced a principle of nervous action, viz., that when a centre discharges itself and one route for the current is closed, the current flows in other directions, and thus the gait in locomotor ataxy may be explained. In speaking of the ophthalmoscope he says it should be used by routine in intra-cranial diseases, instancing optic neuritis as sometimes an early symptom of locomotor ataxy, and saying that the process of embolism may be here fully studied. (A good article on this subject by Noyes, of New York, may be found in the *American Journal of Medical Science*, for October, 1877.) Tubercles in the choroid in cases of acute tuberculosis may confirm a doubtful diagnosis, as may also the evidences of syphilitic choroiditis, (described by Hutchinson,) in cases of suspected hereditary disease. The well-known retinal changes in some cases of chronic Bright's disease are also mentioned, and attention called to the fact that though usually a late symptom it is not very uncommon for the ophthalmic surgeon to be the first to suspect renal disease, as the changes are generally found with the small kidney and not accompanied with dropsy.

S. B. St. J.

PIGMENT OF THE RETINA.

The coloring matter of the retina has recieved a great deal of attention at the hands of physiologists lately. Until recently, it was supposed that the retina was destitute of pigment, because when the eye is examined under ordinary conditions, none is found. Recent investigations have demonstrated the existence of a pigment highly sensitive to light, which discolors it. W. Kuhne, of the Phys. Inst. of the Univ. of Heidelberg, in the Klin-Monatsblätter für Augenheilkunde, says, "A colored rabbit was securely fastened opposite a square opening cut in a window shutter, the head covered for five minutes with a cloth, and then exposed for three minutes. The head was then cut off, and one eye enucleated under sodium light, and placed in a five per cent. solution of alum. After two minutes, the other eye was treated in the same way. The next morning the outside of the retina showed a clear square spot in the second eye, quite white; in the first, somewhat pink." In subsequent experi-

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ments, he got more perfect pictures of the window, showing the cross-bars of the sashes in delicate pink lines. He gives this process the name of optography.

In a later report, Kuhne announces the extension of his investigation to the human eye, in the case of a hospital patient who died in the night. Upon examination of the eye under sodium light, the pink coloring matter was found in abundance except at the macula. The pigment could also be recognized with the microscope.

Capranica Stefano (*Annales I'oculistiques*) finds the pigment insoluble in water, alkalies or acids, but soluble in alcohol, ether, chloroform or bisulph-carbon making a golden-yellow solution. Concentrated sulph. acid changes it to violet. Nitric Acid makes it blue and then decolorizes it. Solution of iodine changes it to green. These reactions are the same as those with pigment from birds and reptiles. The spectroscope shows two absorption bands, the bands being identical with solutions from frog, lizard and chicken. Spectroscopically and photo-chemically, this substance corresponds exactly with the luteine described by Hoppe-Seyler and Thudicum, and found in the corpus between the yolk of egg, the serum of blood, butter and adipose tissue, as well as some ordinary vegetable. Finally Capranica thinks he has found "that there exists already in the ovum a coloring matter, destined to enter into the composition of the future retina." S. B. St. J.

OPTIC NEURITIS FROM LEAD POISONING.

Galezowski (*Recveil d' ophthalmologie*) describes a form of progressive atrophy of the optic nerve from lead poisoning, associated with muscular atrophy and paralysis. The lesions are caused by salts of lead lodged in the nerve tissue. The disturbances of vision resemble those of hysteria. The lesion is supposed to be in the brain and not in the optic nerve primarily, the optic neuritis being secondary. The same author advocates the use of the thermometer in ophthalmology, using an instrument small enough to go between the eye lids, and says that the eye undergoes more variatons of temperature than any other organ, and often without participation of any other organs. The temperature rises or falls one or two degrees, or even two and one-half degrees centrigrade, especially in the course of catarrhal conjunctivitis of iritis or irido-choroiditis. We cannot yet tell what may be the real value of its use. The normal temperature of the eye is thirty-six five-tenths and thirty-sixth seven-tenths. As general conclusions, he gives: *First*—The temperature of the eye increases eight-tenths to one degree in all affections with free discharge. *Second*—In certain inflammations of iris choroid and cornea the temperature is same as general temperature, or below it. *Third*—The temperature of the eye rises or falls as the disease aggravates or diminishes.

S. B. St. J.

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VEREBÉLYI ON TREATMENT OF CONGENITAL CLUB-FOOT BY SUBPERIOSTEAL REMOVAL OF THE ASTRAGALUS.

(*London Medical Record*, November 1877.)

The author describes a case of double talipes in a child five and one-half years old. Tenotomy and the application of a plaster of Paris bandage having failed, the astragalus of one foot, which presented the principal obstacle to reduction, was laid bare by an incision, and, the periosteum having been stripped off, was removed. The foot was then brought into proper position, in which it was retained by a fenestrated plaster of Paris bandage, and afterward by a proper apparatus. After the healing of the wound, the foot easily preserved its proper direction. N. M. S.

PIROGOFF'S OPERATION FOR CLUB-FOOT.

(*London Medical Record*, December 15, 1877.)

Dr. Weinlicher showed a patient to the Imperial Royal Medical Society of Vienna, on both of whose feet he had performed Pirogoff's operation, on account of a high degree of club-foot. In both instances he had fixed the os calcis to the bones of the leg by means of pegs, and thus produced anchylosis. Unfavorable circumstances delayed healing for two months in one foot, and three months in the other; and while the plastic result was good, the function of the limb was not restored, though improvement was to be expected. There was much tenderness in the heel. N. M. S.

ERRATA.—In Dr. Hamilton's paper on "Alimentation in Surgical Accidents," etc., read before the Academy of Medicine, and published in the last number of this journal, page 32, fifteenth line, for "or of chronic," read *or of acute or chronic;* page 34, fifth line, for "one change," read *the change;* twenty-sixth line, omit "digestion and assimilation wait on appetite; page 35, seventh line, for "rich," read *sick;* thirty-second line, for "so far inferior," read *far inferior;* page 38, before the seventh paragraph, add, *I will make the following brief summary;* page 40, seventh proposition, read "morphine and *other* narcotics." There are a few other minor errata, which the reader will be able to correct himself.

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THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY,

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EDWARD J. BERMINGHAM, M. D., and FREDERICK A. LYONS, M. D.

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LECTURES.

CLINICAL LECTURE ON NEW REMEDIES,

Delivered at the Pennsylvania Hospital,

BY

JACOB M. DA COSTA, M. D.,

Professor of the Theory and Practice of Medicine in the Jefferson Medical School, Philadelphia.

I. CHRYSOPHANIC ACID IN CHRONIC PSORIASIS. II. ERGOT IN DIABETES INSIPIDUS. III. JABORANDI IN PLEURAL EFFUSION.

To-day's lecture might, with propriety, be called a clinic of new remedies. I wish to call your attention to three very interesting cases in which new remedies have been successfully employed.

CHRYSOPHANIC ACID IN CHRONIC PSORIASIS.

J. B., aged 27, a teamster by occupation. The history of this case extends a long way back. The patient tells us that during the hot weather of July, 1867, his hair all fell out and an eruption appeared on his scalp. He says that he thinks he contracted the disease from

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a friend, (not a female friend,) who was afflicted in the same way. He utterly denies any syphilitic contagion, says that he never had any sore throat, and that there were none of the other constitutional symptoms present. After several months had passed, the eruption left his head, and the hair grew again thickly. There was no local application made at the time, except salt and water, and no internal treatment whatsoever. After leaving his head, the eruption appeared on his legs, and has remained there ever since. About six months ago he was admitted to the hospital for the first time. His arms, legs and trunk, were then covered with the eruption. This eruption was reddish and scaly; the skin was thickened, brazed, and fissured. The eruption was least visible upon the scalp and forehead, and was most characteristic about the joints, particularly the elbow joints. The man had been using a great variety of remedies with no success at all. Among other things he had tried arsenic, in the form of arsenious acid, and also the so-called "Asiatic pill," but everything failed utterly to do him any permanent good.

I then determined to make trial of a remedy which I had seen highly recommended in one of the English journals, viz: chrysophanic acid ointment. I used the ointment with a strength of one drachm of the acid to one ounce of simple cerate, and caused it to be well rubbed into the skin of the whole body every evening. After several days' use of this ointment, the skin became much paler and smoother, and the scales began to disappear. Unfortunately the man took it into his head to leave us just at this juncture, and he has been entirely lost to our sight until to-day, when he again came back to the hospital, and I hope will stay with us long enough to enable us to thoroughly test the value of this new remedy.

Now that he is stripped, you see what a marked case of the disease he presents. There is no healthy skin left upon the body, except upon the front and upper part of the chest, the face, forehead, scalp, and hands, all the rest of the body is covered with rough, uneven, reddish scales. You see that the eruption presents the most typical character, just about the elbow joints. The case is not nearly so bad to-day, however, as when we began the treatment.

I shall place the man once more upon chrysophanic acid. For purposes of cleanliness merely, I shall order him a lukewarm bath daily, in which he must remain for ten or fifteen minutes. After his baths I will have him rapidly, but thoroughly, dried. During the second week of treatment, I will have the bath rendered very slightly alkaline, by putting, say one-half ounce of the carbonate of potassium into the water. Then I shall cause the man to rub the chrysophanic acid ointment carefully into the skin of his whole body. Every evening, in the course of a few applications, I think the improvement will be marked.

ERGOT IN DIABETES INSIPIDUS.

This man was admitted to the hospital on November 26th, 1877.

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He was then in very poor health, complaining of the daily passage of very large quantities of urine—ten pints daily. He was only moderately thirsty, and averred positively that he passed more water than he drank. The loss of flesh was marked, and there was some irritation of the neck of the bladder. His bladder had been upon several occasions sounded for calculi, but none had been found. Under my direction, the case was carefully watched, and it did really seem as if the outgo was greater than the income of water—the man passed daily ten pints by actual measurement. There was not a particle of sugar or albumen in the urine. I at once recognized the case as one of diabetes insipidus, or polyuria. This disease consists in the passage of large quantities of urine, containing no albumen nor sugar, and is attended by wasting as in true diabetes. It is often found in combination with actual disease of the nervous system, and is generally a condition very difficult of eradication.

As a venture, and upon general principles, I placed the man upon fluid extract of ergot, which treatment had been followed by striking success, *i. e.*, complete cure, in two cases in my private practice. I put him upon an initial dose of half a drachm of the fluid extract, thrice daily, the dose to be increased gradually; increased in size, first, to one drachm, and then to two drachms. There was at once apparent, a great reduction in the quantity of urine passed daily. From ten pints it fell to six pints daily, then to three, where it now stands. Even before reaching the present limit, I ordered the dose to be gradually reduced in size, first to one drachm, and then to half a drachm. Then it was stopped altogether, and mint water substituted in its place. This mint water, employed as a slight stomachic, is all that the man is now taking. For the past two weeks, he has had no ergot, and I may, therefore, consider him permanently cured. The amount of urine daily passed varies between two and three pints, that is, the amount is just about normal. Within the past week, he has had an operation for phimosis performed on him by the resident surgeon, which he has stood very well. He leaves the hospital, to-day, entirely cured, and strong—feeling better than ever in his life before, so that I have every reason to hope that the cure will be permanent. For the last two or three days, the man has been taking a tablespoonful of cod-liver oil, thrice daily—this to strengthen his digestion and general system.

JABORANDI IN PLEURAL EFFUSION.

I. L. C., aged 23, a weaver by trade, was much exposed last summer to wet weather, while at the seashore. Has had occasional cough and pains in the left chest, during the fall. The pain was, at times, so severe, that he had to lean his breast against a beam while weaving. These pains finally rendered it necessary for him to give up his trade. Within the past four or five months, he has had dyspnœa, and has noticed blood in his sputa. Three months ago, he was admitted to another hospital in this city. While there, his

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thoracic symptoms were found to depend upon the presence of a large pleuritic effusion. Aspiration was performed; and thirty-six ounces of a clear, serous fluid was drawn off. After this operation, the shortness of breath, chills and pain speedily ceased, and he was discharged, apparently well. Since then, there seems to have been a return of the effusion, for he tells us that the pains and dyspnœa came on again.

He was admitted to this hospital on December 29th of last year, suffering from severe pain and dyspnœa, chills, and general wretchedness. His temperature was 101°, and percussion showed that his left chest was full of fluid. I was tempted to perform aspiration at once, a second time, for the effusion extended very high up, and his heart was pushed far over to the right; the expiratory murmur also was very feeble. I have, however, so often been able to notice the fact, that when aspiration is performed more than once, the effused fluid is exceedingly likely to become purulent, and so give rise to empyema, that I determined not to attempt surgical interference a second time, but to try a remedy which some French clinicians have lately used in cases of pleurisy with very great success, viz., jaborandi. I therefore ordered the patient one drachm of the fluid extract of jaborandi, four times daily. The results have been truly marvelous. For nearly a week, his temperature has been down to 98°–99°, the chills, pain, and dyspnœa, have altogether left him; his pulse has fallen to 86–96, per minute, and his respiration to 20. As regards the physical signs, I may state that there is no dullness upon percussion, except at the very bottom of the chest, and that the respiratory murmur is clear as far down as a level three inches below the angle of the scapula, that is to say, the murmur is only feeble over the spot of dullness. The effusion has, therefore, almost entirely disappeared. There is not more than one-quarter of an inch difference between the measurements of the two sides.

The patient has been sweating profusely while under the jaborandi treatment, so that I have no doubt at all that a large part of the effusion has been drawn off through the pores of the skin. He has also passed water very freely. The jaborandi has plainly done good by means of its diuretic and diaphoretic action. The result is most gratifying to me. The man is practically cured, and what is better, I think his cure will be permanent. In general, it may be laid down as a common fact, that fluid removed from the chest by medicinal means is far less likely to recur than if removed by surgical interference, that is, by aspiration. Do not understand me as taking a position againt aspiration, it is a most valuable therapeutic agent, and I often employ it, but I advise you always to use it as a last resort, where symptoms of dyspnœa and cardiac disturbance are urgent, and to try first in every case to treat the patient medicinally.

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LECTURES ON COMPOUND COMMINUTED FRACTURE OF RIGHT ELBOW, AND DISLOCATION OF RIGHT HUMERUS, WITH POST-MORTEM EXAMINATION.

BY
JARVIS S. WIGHT, M. D.,
Professor of Surgery in the Long Island College Hospital, Brooklyn, N. Y.

GENTLEMEN—I have summoned you here at this hour, 8 P. M., to see an African negro who has been very severely injured. He is the steward of a ship; he is sixty-one years of age; he fell through the hatchway, from the deck into the hold, upon some slates that were laid in with their edges up, a distance of about twelve feet.

FIRST—He has, as you see, a transverse supra-condyloid fracture of the left femur, and I call your attention to the fact that he had sixteen years ago a fracture of the neck of the left femur, followed by considerable shortening.

SECOND—He has some contusion of the head; the pupils are dilated, but there are no indications of serious injury to the brain.

THIRD—There is a compound, comminuted fracture at the right elbow-joint, involving the radius, the ulna, and the humerus. The opening is small, and over the olecranon.

FOURTH—The head of the right humerus is dislocated. The greater tuberosity is under the coracoid process, and the head of the humerus projects beyond into the axilla.

FIFTH—There is great shock. The molecular effect of the fall has disturbed the organic relations of the nervous system, rudely interfering with the circulation. In order to arrest, in some measure, the depression, the patient has had hypodermic injections of whiskey, from one-half to one drachm at a time.

It very rarely happens that the head of the humerus is dislocated on the dorsum of the scapula. This subject need not detain us at present.

In the great majority of cases the head of the humerus is dislocated into some part of the axilla. Remember the boundaries of the axilla and you will realize the truth of this statement. The upper end of the dislocated humerus may be (1) under the neck of the scapula; (2) under the coracoid process; or (3) under the clavicle.

FIRST—In the sub-glenoid dislocation the head of the humerus is in front of the latissimus dorsi, which is the posterior boundary of the axilla; it is above the floor of the axilla; and it is, therefore, practically in the axilla.

SECOND—In the sub-coracoid dislocation the head of the humerus is back of the pectoralis major, which is the anterior boundary of the axilla; it is above the floor of the axilla; and it is, therefore, practically in the axilla.

THIRD—In the sub-clavicular dislocation the head of the humerus is under the pectoralis major; it is in front of the scapula; and it is, therefore, in the axilla.

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Admit that the walls of the axilla in these three instances may be somewhat displaced, yet practically the head of the humerus does not go out of the axillary space.

And this gives us a very simple principle of classification. The head of the humerus is dislocated into the axilla, (1) under the neck of the scapula; (2) under the coracoid process; and (3) under the clavicle.

Shall we reduce this dislocation while the patient is in a state of continued shock? Yes, if he can take ether; for sometimes ether will mitigate the severity of shock. Let me remind you that it is perilous to give chloroform to an African negro—a lesson taught me by experience. See how readily and kindly our patient goes under the influence of ether. My clinical assistant will now support on his hands this mangled limb in the most careful and tender manner, and leave me the upper part of the arm for manipulation. The nurse brings me a soft pillow of medium size, such as you can get in every house. I place this pillow gently between the arm and chest-wall, and put the bottom of my *stockinged* foot upon it, when I firmly grasp the sound part of the arm and pull outward and downward, at the same time pushing the pillow upward before my foot. The dislocated bone is reduced with great ease.

I now observe that the patient is very much depressed. He is almost in a state of collapse. To exsect the elbow-joint now would be full of peril to the patient; perhaps this may be done in the morning. I will put this injured arm in a right-angled trough of wire-cloth, well lined with oakum, applying carbolized oil to protect and quiet the contused and lacerated tissues. I will sustain the patient with wine and milk, and alleviate his pain with anodynes. The patient will be taken to his bed in the ward, and you will be told in the morning how he passed the night.

Before you go, let me explain to you some points in the mechanism of reducing a dislocation of the humerus. The pillow presses:

FIRST—*On the chest-wall,* which is quite immovable; and the scapula is attached to the chest-wall by firm fascia, by strong muscles, and by the clavicle; and the motions of the scapula are modified by these attachments.

SECOND—*On the pectoralis major muscle:* That is, the inferior fibres of this muscle. These fibres are made tense, and they have a tendency to pull the humerus inward and downward; but the pillow prevents the inward tendency. Hence, any motion coming from this cause must be downward.

THIRD—*On the latissimus dorsi muscle:* The fibres of this muscle are made tense by the pressure of the pillow, and they have a tendency to pull the humerus inward and downward; but the pillow prevents the inward tendency. Hence, any motion coming from this cause must be downward.

FOURTH—*On the pectoralis major and the latissimus dorsi.* The pillow presses upward, and may be looked upon as immovable. The

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hands of the surgeon pull downward on the arm: this draws upon the tendons of the great pectoral and the broad dorsal muscles. The fibres of these muscles are drawn around the pillow and the surgeon's foot, and the traction extends to the attachment of these muscles to the trunk. Hence, the force is applied so as to pull the trunk and the scapula with it upward. At the same time, the upper limb moves downward, and in the sub-glenoid dislocation, the head of the humerus is carried over the border of the glenoid cavity; in the sub-coracoid dislocation, the head of the humerus is liberated from the coracoid process and carried over the border of the glenoid cavity; and in the sub-clavicular dislocation, the head of the humerus is drawn downward under the coracoid process, and carried over the border of the glenoid cavity: hence the pectoralis major and the latissimus dorsi muscles may be made to assist in the reduction of a dislocation of the humerus. My practical observations are in accord with these statements.

FIFTH—*On the axillary border of the scapula.* Any pressure of the pillow on the axillary border of the scapula tends to move the upper end of the humerus outward toward the glenoid cavity, and the scapula upward.

SIXTH—*On the inner-side of the upper part of the arm;* and it pushes the head of the humerus away from the chest-wall by antagonizing the teres major, the sub-scapularis, and especially the middle fibres of the pectoralis major. Any motion coming from this cause is away from the chest-wall towards the glenoid cavity.

In the mean time, remember that the lower end of the arm is abducted and elevated, by which the deltoid, and any remains of the supra-spinatus, are relaxed, and the untorn part of the capsular ligament is "taken off the stretch."

When the pillow begins to press upon the arm, the arm must be rotated outward. This, as you can readily see, prevents any severe pressure on the axillary vessels and nerves, by turning them out of the way, and it turns the head of the humerus towards the glenoid cavity. *And now traction on the arm, outward and downward by the surgeon's hands, brings into play all the forces above described, and the head of the humerus is induced into the glenoid cavity;* and finally, as the reduction is completed, the entire upper limb is carried across the chest.

Gentlemen, I have to tell you, to-day, that our patient died about two o'clock this morning. If I had done more for him last evening he would have died on the table. It is our duty, at times, not to operate; you must do the best you can in the circumstances in which you are placed, and Sir Astley Cooper must do the best he can in the circumstances in which he is placed.

I shall omit the didactic lecture this morning, and occupy the hour investigating this injured upper limb. Let me direct your attention

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at first to the fracture: I will exsect the elbow-joint. The point of the knife is entered over the ulna, two inches below the olecranon, and now cuts through the soft parts for a distance of four inches directly upward. I feel the blade grating on the fragments of bone. The soft parts are separated by retractors; the fragments of bone are separated from the periosteum, and removed—it being necessary to extend the incision about two inches further towards the hand. Here are seventeen fragments, some are sharp-pointed, and some are rough. They comprise two inches of the lower end of the humerus, and about four inches of the upper ends of the radius and ulna—a loss of six inches of the bones of the upper limb. To lose six inches of the upper limb and save the hand, is better than to lose the hand. And now if this cadaver were a patient it would be advantageous to put what there is left of his upper limb on a posterior double-angled splint, such as you have seen me use for compound fractures of the forearm.

In the second place, let me direct your attention to the right shoulder. You will not often have an opportunity like this to study the pathology of a dislocation. The work before us is to determine what structures about the shoulder-joint have been injured in this case. Let me call your attention to the fact, that there is rigor mortis. This need not detain us now. It may somewhat interfere with our investigations. The knife is inserted over the acromion, and an incision four or five inches long is made through the deltoid in a direction downward, upon the greater tuberosity and the shaft of the humerus. One part of the deltoid is drawn forward, and the other part is drawn backward, and the incision is extended above and below, so as to give room for complete observation. You will observe that the tendon of the teres minor muscle is torn from the greater tuberosity of the humerus. The muscular fibres of the infra-spinatus are lacerated, and there is some extravasated blood among them. The muscular fibres of the supra-spinatus are very much lacerated, and the tendon is mostly torn from the greater tuberosity. Among these structures is extravasated blood. The capsular ligament of the shoulder-joint is intact over the greater tuberosity of the humerus. I now put my finger into the posterior part of the opening we have made, and find the capsular ligament torn from the neck of the humerus, as far forward as the posterior limit of the greater tuberosity. And I now put my finger into the anterior part of the opening we have made, and find the capsular ligament torn from the neck of the humerus nearly as far outward as the greater tuberosity—some fibres being still attached to the lesser tuberosity. The head of the humerus remains firmly in the glenoid cavity.

The circumference of the humerus at the anatomical neck is from five to six inches; the greater tuberosity takes up about two inches, the lesser tuberosity and the bicipital groove take up about one inch, so that from the greater to the lesser tuberosity internally there would be about three inches of the anatomical neck of the humerus. Hence,

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in this case more than one-half of the capsular ligament has been torn from the humerus—transversely to the axis of the shaft of the bone; and through this rent the head of the humerus was driven at the time of its dislocation.

I will now cut the intact portion, less than one-half of the capsular ligament, and the head of the humerus is liberated. It readily goes into the axilla; observe how the greater tuberosity gets under the coracoid process, while the head of the humerus projects beyond it. See the long tendon of the biceps comes out of the bicipital groove, being still attached to the scapula. It is dislocated. Now put the head of the humerus back into the glenoid cavity, and the long tendon of the biceps resumes its place in the bicipital groove. How can we interpret these facts? Why, in this case there must have been a dislocation of the long tendon of the biceps, and last evening, when I reduced the dislocated humerus, the dislocated tendon of the biceps must have been reduced also. Does this tendon break away from its scapular attachment, or is it dislocated when the humerus is dislocated? This is a very difficult question to answer. So far as I can now judge, the long tendon of the biceps is more likely to be torn from the bicipital groove than from the scapular attachment. Let me now show you the lacerated fibres of the sub-scapularis. Note the very considerable extravasation extending from the inner aspect of the humerus into the tissues of the axilla. From this exhibition you can get an idea of the very considerable injury done to the peri-articular structures by a dislocation.

And now let me call your attention to some anatomical points and mechanical questions of importance in regard to the reduction of dislocations of the humerus.

First—The acromion projects beyond the glenoid cavity, on the average about two inches, sometimes beyond the greater tuberosity; sometimes even with it, and sometimes not so far as this process; generally the extremity of the acromion is directly over the greater tuberosity of the humerus.

Second—There is but very little space between the upper end of the humerus and the acromion process. The acromion protects the upper end of the humerus, and limits the upward motion of the arm.

Third—The anatomical neck of the humerus is very short, and meets the axis of the shaft of the humerus at an angle of about forty degrees. The anatomical neck and the surgical neck very nearly meet on the inner side of the humerus.

Now let us abduct the arm and elevate it. It goes readily, till the axis of the humerus is nearly at a right angle with the axis of the body, when you see it will not go further, *because the greater tuberosity comes in contact with the acromion.* Let us try to move this arm further upward; see the head of the humerus is pushed out of the glenoid cavity. The greater tuberosity is the fulcrum; the distance from it to the elbow is the power-arm of the lever; and the anatomical neck is the weight-arm of the lever. Approximately ten pounds

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applied to the lower end of the arm, the greater tuberosity being against the acromion, would overcome one hundred pounds of resistance before the head of the humerus. Hence, immense force can be applied to the capsular ligament, by abducting and elevating the arm.

This nurse has removed the clothing from his right shoulder, in order that I may demonstrate to you the facts. His arm may be elevated about to a right angle with the body, where it is arrested. Hold the scapula immovable and the arm will not go up higher; let go the scapula and the arm will move up somewhat higher, *because the scapula is tilted upward as the elbow moves upward.* So much for these motions when the parts are in a normal condition, but the same principles control the motions of the dislocated humerus, as we shall soon make plain.

In another relation, the facts are different. Do not forget that the humerus will rotate through an arc of about 90°. Now, let us elevate the arm, and *supinate* it at the same time. (1) The head of the humerus rotates in the glenoid cavity; (2) The greater tuberosity is turned away from the acromion toward the axilla; (3) the acromion projects against the surgical neck of the humerus on the inner side; (4) the head of the humerus projects under the acromion, being turned, as it were, upside down, in the glenoid cavity; (5) the scapula is tilted upward; and (6) the upper limb is found to be somewhat directly upward.

In the next place, suppose we have any one of the forms of dislocations at the shoulder that we have denominated *axillary.* The head of the dislocated humerus in general, will look nearly in the same direction as it did before displacement, that is, toward the chest-wall. Now abduct and elevate the dislocated humerus. The greater tuberosity and the outer side of the upper end of the shaft will move toward the glenoid cavity; the head of the humerus will continue to look directly away from the glenoid cavity; and the upper motion of the arm will be arrested by the acromion process. *Under such conditions, the head of the humerus will not go into the glenoid cavity.*

Please to remember that the humerus is dislocated, that the arm is abducted and elevated, and that the head of the humerus looks away from the glenoid cavity; the humerus is, as it were, turned inside out. You will now observe that *supination* of the arm will turn the head of the humerous forward, inward, and backward, toward the glenoid cavity; but *supination* will sometimes enable the surgeon to reduce the dislocation, and sometimes it will not enable him to do so. I have succeeded, and I have failed to reduce a dislocation of the humerus by these manipulations. The failure may have been due to: (1) the downward traction of the pectoralis major, and the latissimus dorsi; (2) the entanglement of the head of the humerus by the sub-scapularis; (3) the obstruction offered by the untorn portion of the capsular ligament; but I have not as yet been able to satisfy myself as to the primitive causes of failure under the circumstances.

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It must, however, be admitted that the upward traction on the arm, combined with rotation, is a most effective way to break up the adhesions of an ancient dislocation, and it may be as dangerous as it is effective, but even then it will not always reduce the dislocation. And after the adhesions have been broken up I have made the reduction by abducting and elevating the arm, rotating it outward and lifting the upper end of the arm away from the chest-wall out of the axilla, so that we come back to the classical method of reducing a dislocation of the humerus.

Let me allude to another point that has received much attention. I refer to the resistance to reduction made by the untorn portion of the capsular ligament. I am speaking now of the shoulder-joint. There are two facts that you already know, viz.:

FIRST—Complete anæsthesia will relax muscular fibres.

SECOND—Complete anæsthesia will not relax ligamentous fibres.

There are two other facts that have been repeatedly demonstrated by observation, viz.: the same means (1) when unaided by anæsthesia will fail to reduce a dislocation of the humerus; and (2) when aided by anæsthesia will accomplish the reduction of a dislocated humerus.

The anæsthesia has removed the muscular obstruction, and it has not removed the ligamentous obstruction; hence, the obstruction to reduction of a dislocated humerus is sometimes muscular, sometimes ligamentous, and sometimes both muscular and ligamentous. It is important to look at every side of a problem one is called upon to investigate.

Here I may add the following statement, namely, to abduct and elevate the elbow of a dislocated humerus and to lift the upper end of it away from the chest-wall out of the axilla will most effectually relax the untorn portion of the capsular ligament.

Finally, I had proposed to investigate the left hip-joint of this cadaver, but the friends interpose; they say we have done enough, and I must respect their objections and their feelings.

A CLINICAL LECTURE ON ANGINA PECTORIS,

Delivered at the Jefferson Medical College Hospital of Philadelphia,
BY
JOHN B. ROBERTS, M. D.,
One of the Physicians to the Hospital.

I shall show you this morning, gentlemen, two cases which are interesting illustrations of a malady that is not very frequent, but is of great importance in a clinical point of view. First, let us hear the history of this man. John L., aged 32, comes to the hospital complaining of sudden paroxysms of severe pain in the cardiac region, which, he says, occur when he is hurried or excited, though sometimes they come on at night, so that he wakes in great pain and distress. The pain extends down both arms, but, he thinks, especially the left,

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and during the attack, he suffers from dryness of the mouth, and is afraid to take a deep breath lest it should increase the pain. The feeling of suffocation and the severity of the pain are such, that he feels as if he were going to die. This is the account of the attacks, which have of late rather increased in intensity; and, in addition, we find that he had some rheumatic trouble in his feet about seventeen years ago. Of course, these symptoms tell us to examine the chest, and finding nothing important in the lungs, we investigate the heart. The open beat is seen and felt outside of and below the left nipple, and on auscultation, there is perceived a loud, shrill murmur, diastolic in tune, and heard best in the vicinity of the aortic cartilage; in addition, there is heard a slight murmur with the systole of the heart, which is also most distinct at the right side of the sternum, near the second cartilage. These murmurs are easily understood, if you recollect what should be the position of the aortic valves during the two sounds of the heart. During the first sound, the aortic leaflets should be widely open, and hence, murmur produced at that time indicates roughening, or some obstruction to the free exit of the blood current; with the second sound, however, the valves should be shut to prevent a reflux of the blood; but as we have a loud prolonged murmur at the orifice during diastole, it is evident that there must be free regurgitation. This is further substantiated by the character of the radial pulse, which strikes the finger with considerable force, but suddenly sinks away again, or, as we say, receding. Finally, the increased size of the heart, without a corresponding augmentation of the force of the impulse, renders it probable that dilatation exists as a consequence of the valvular lesions. Having thus determined that this patient has dilated heart, with regurgitation at the aortic orifice, and, perhaps, a slight amount of roughening, let us turn to the woman who comes with somewhat similar symptoms.

She is thirty-eight years of age, and says she has palpitation of the heart, and paroxysmal pain which is severe and shoots down her arms. These attacks are produced by any excitement, and during them, she becomes unconscious. She has never had rheumatism, and though nervous, has never been hysterical, and does not belong to an hysterical family, at least, not in the ordinary acceptation of the word hysterical. Examination of the lungs show signs of some consolidation at the right apex. Over the cardiac area is heard a harsh systolic murmur, with its point of greatest intensity at the apex, though it is also heard at the aorta; but as heard then, it is probably a transmitted sound from the mitral orifice. You must recollect that the four valves of the heart are situated very near together, in fact, in a space small enough to be covered, perhaps, by a half dollar; hence, to distinguish at which valve the murmur is generated, it is necessary to place the stethescope at other points than over the anatomical seats of the valves. These points have been determined clinically, and are well known to you, viz., apex, ensiform cartilage, second right costal cartilage and second left costal cartilage, or rather

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in the interspaces just below these costal cartilages. There is in this heart a strong impulse which is somewhat extended, hence, hypertrophy may be supposed to exist. In other respects, the woman seems to be in good general health.

You have now the history of these cases, and a report on the condition of the heart in each. The characteristic symptoms at once suggest as the diagnosis angina pectoris, which is evidently correct in regard to the first patient, but must be accepted with a little more hesitation in the second instance.

Let us then discuss the symptoms, pathology, diagnosis, and treatment of this painful disease; and first let me give you a hint as to the name angina, which you hear applied to many diseases so different in character. From its derivation it means something that throttles or suffocates, and was accordingly, by the older writers, applied to many diseases, having dyspnœa or difficult respiration for a symptom. Now you understand why it was applied to various kinds of sore throat which are so distant in their relationship to angina pectoris. The disease is characterized by sudden lancinating pain, radiating from the præcardial region into the neck and arms, and accompanied by a sense of constriction. There is apparent dyspnœa, produced by the intense suffering, which makes the patient afraid to breathe, though if he be commanded to take a deep inspiration, he can do so, and may thus cut short the paroxysm. Such is the case with this man. The pain is apt to shoot down the arms, and is especially noticed in the left arm as a rule; occasionally, however, as in a case under my care a year or two ago, the pain seems to begin in the hands and afterwards proceeds to the cardiac region. The paroxysms of pain may be induced by any exertion or emotion which quickens the circulation, and it is not unusual for patients to have distressing dreams at night and to wake with intense pain, and the feeling of impending death which so generally characterizes the affection. The patient may suffer so exquisitely that syncope may occur, as is stated to be the case in the woman before you. During the paroxysm the pulse may be greatly disturbed, while at other times its rhythm and force are not much interfered with. It has been stated that there is during the occurrence of angina pectoris a great difference in the strength of the pulse, felt in the two radial arteries, but this, I think, has hardly been fully established. The intervals between the attacks of pain are irregular, and usually the paroxysms increase in frequency and severity, until the patient at last succumbs to the disease in one of these attacks, or is carried off by some intercurrent affection.

If the heart of such a patient be examined, what do we find? Usually there is organic disease of the heart or aorta, but no one lesion seems to be always present. A good many cases show atheromatous change of the coronary arteries, others fatty degeneration of the muscular structure of the heart, while in other instances again there is valvular disease or aneurism of the aorta. It would seem that most instances occur when there is fatty degeneration of the cardiac walls,

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or lesions at the aorta, such as regurgitation, liable to induce overdistension of the ventricles. The pain which is probably neuralgic in character, and connected with the cardiac plexus, whence it is reflected by pneumogastric and sympathetic branches, is experienced whenever emotion or excitement causes sufficient disturbance of the circulation to produce overdistension and consequent paralysis or spasm of the heart. Fortunately I am able to show you a specimen to-day, taken from a patient of Dr. Ingram, which presents not only a rare lesion of the heart, but is interesting as being derived from a man who died a few days ago in a paroxysm of angina. The doctor had seen the man some weeks previously in a typical attack, and there is hence no doubt as to the diagnosis of angina pectoris. He was sent for hurriedly, about two weeks ago, and found the patient dead. The heart is before you, but has not as yet been thoroughly examined with the microscope. It is somewhat dilated, and shows a number of growths situated in the wall of the right ventricle, one of which involves the tricuspid valve. The coronary arteries are patulous, and the valves, except the tricuspid, normal. Further examination will probably show fatty change in the muscular fibre of this organ, and it is probable that these growths are malignant. You see then that there is no constant lesion in angina pectoris, though there is generally perhaps some fatty transformation, alone or connected with other lesions. You have heard then something of the symptoms and pathology of angina, and have seen this most interesting specimen; it remains to discuss the differential diagnosis and the treatment.

Intercostal neuralgia, with palpitation of the heart, may be discriminated, as a rule, by the three spots of tenderness found in the course of the intercostal nerve, as well as by the less serious character of the pain. There is a rare affection, sometimes called cardiac epilepsy, similar to angina pectoris, but in such cases, there is unconsciousness, generally primarily, while in angina the unconsciousness, if it occurs at all, comes secondarily as a result of the exquisite pain. Hysterical women sometimes have symptoms allied to angina in connection with ordinary neuralgia of the chest walls, and may complain of intense pain, and even lose consciousness. Hence we must be careful in making the diagnosis, and learn all we can of the antecedent history of the patient. Indeed, in the woman just before you, I have not made up my mind yet as to the true nature of the case, and have therefore made in her case a provisional diagnosis, while in the man, who has been under observation longer, and presents symptoms of aortic regurgitation and dilatation, there is no doubt regarding the anginose character of his disease.

The treatment must vary according to whether you are called to the patient during the paroxysm or in the interval. When you find him suffering this intense pain, and afraid to breathe, order him to make an effort to respire, and assure him that it may relieve the pain, or at any rate will have little tendency to increase it. If the case be one of moderate severity, hot whiskey punch, or some aromatic, may

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relieve; or spirit of chloroform, or ether, may be administered. The best remedy, however, of all, is a full dose of morphia, say a half or three-quarters of a grain, hypodermically. Resort may be had to inhalations of chloroform or nitrite of amyl, which will probably be of service; but our great reliance in painful spasmodic affections is morphia, given subcutaneously. During the interim between the paroxysms, attend to the general health, tell the patient to avoid excitement; dyspepsia and all causes liable to induce a paroxysm; and relieve, if possible, the cardiac disease, or at least endeavor to prevent overdistention or overwork of the disabled organ. Arsenic, belladonna, and digitalis, may at times be found available, and will apparently prolong the interval. Bromide of ammonium has been recommended, and cases have been reported where it seemed to cure the predisposition to attacks of angina. This man has been taking bromide of sodium with a similar end in view, and as he has no doubt tried many other remedies; it shall be continued in order to give it a fair trial. The woman's case shall be investigated further to see if the affection be true angina pectoris or an hysterical disorder, and she can then be treated accordingly.

SPONTANEOUS AMPUTATION OF A GANGRENOUS LEG AT THE KNEE-JOINT, UNDER THE HOT WATER TREATMENT.*

SERVICE OF
DR. FRANK H. HAMILTON,
Bellevue Hospital.

December 18, 1877, John Meagher, aged about 25 years, a switchman on the Long Island Railroad, was run over by two platform cars. During three days, he remained under the care of a physician at Hunter's Point, refusing to submit to amputation.

December 21, he was admitted to my wards, Bellevue Hospital. My House-Surgeon, Dr. W. S. Halsted, who examined him at once, and who was throughout in immediate charge of him, reported to me that he was, on admission, pale, and a little bronzed—his breath had a slight saccharine odor, the surface of his body was cold, his pulse weak, thready and rapid. He was delirious, talking in a low voice and incoherently.

The right thigh had suffered a severe laceration just above the knee; the wound being about ten inches long, and closed by sutures. It was emitting a strong gangrenous odor. On removing the sutures, the underlying structures were found extensively contused, the bone bare, and the wound filled with masses of undetached gangrenous tissue.

His left thigh was broken about three inches above the knee-joint, the upper fragment penetrating the joint. The whole limb was cold, swollen, discolored, emphysematous and pulseless.

*Reported to the Surgical Section of the Academy of Medicine, Feb. 12, 1878.

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His condition did not warrant an amputation. In this opinion, Dr. Wood and the House Staff concurred. A long splint was laid beside the broken limb and secured by bandages, heat applied to the extremities, a weak solution of carbolic acid was employed to correct the fœtor, and nourishment with stimulants were adminstered. Speedy death was anticipated.

On the following day, his mind was more clear, but he was still very feeble, and the gangrene was extending in both limbs. Amputation was advised, but the parents refused their consent.

December 23.—Gangrene still extending; in the left leg involving the whole limb as high as the knee, and a discoloration existing as high as the groin.

The entire left leg and thigh were now enveloped in cotton batting, saturated with hot water—water at about the temperature of one hundred and ten degrees of Fahrenheit—and the laceration on the right thigh was treated in the same manner. Outside of the cotton batting, each limb was enclosed in oiled silk, and the patient was made to repose on a sheet of oil-cloth.

From this time, December 23, to when the left leg was removed at the knee-joint, the hot water was renewed every twenty or thirty minutes, day and night.

December 25, the discoloration, suspected to indicate approaching gangrene, has nearly disappeared from the left thigh, above the fracture. A line of demarcation is forming at the knee-joint. Delirium abating. He begins to take food. Rests well.

December 29, no delirium. Says he feels well.

January 6, 1878, nineteen days after the receipt of the injury, and thirteen days after the commencement of the hot water treatment, the separation at the left knee-joint was so nearly completed that with my scissors I cut the remaining sloughy bands, and removed the leg, without inflicting pain or causing the loss of only a few drops of blood.

The gangrenous slough had already separated from the opposite thigh.

January 7, removed to a water bed, being threatened with a bed sore.

January 15, right knee painful and swollen, but on the following day a profuse discharge occurred from the wound above the knee—probably from the joint—and the patient was relieved.

January 22 to 31, three or four small abscesses appeared on right limb and were opened.

February 8, last report, patient gaining in strength; wounds healing on right limb. Lower fragment of femur, (left limb,) projecting, and the necrosed extremity of bone gradually separating from the shaft. The lower fragment, about four inches, including the joint surface, dead, but still hanging by two bands of living soft tissue. Granulations healthy and cicatrization progressing; water dressings discontinued when the leg separated; balsam of Peru being substituted. His final and complete recovery is now assured. Possibly after a time resection of the bone may be required to make a good stump, but probably not. The lower fragment might be removed at any time

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with the loss of a little blood, but it has been deemed advisable to wait until the patient's strength is better established.

This is not the first time that I have obtained a similar result from this plan of treatment, and while I am not prepared to say that it will always prove successful in arresting traumatic gangrene, and in securing a prompt separation of the dead parts, it is proper to say that the method always deserves a trial when amputation cannot safely be practised.

It is worthy of remark that from the second or third day after the commencement of the hot water applications, there was almost no apparent constitutional disturbance. The patient took no medicines.

A very excellent paper on this subject of Hot Water in Surgery has been written by Dr. Frederick E. Hyde, of this city, formerly my pupil, and published in the *Buffalo Medical Journal* for December, 1875. It may be found in a pamphlet form at the publishing house of Wm. Wood & Co. In this paper, cases 6, 9, 10, 11 and 12 are examples of gangrene which were under my treatment, and which were arrested by hot water, and resulted in spontaneous amputation, and a cure.

NOTES ON THE LOCAL TREATMENT OF BLENNORRHŒA.

BY
J. E. M. LORDLY, M. D., New York.

Having kept a careful record of the last forty-two cases of blennorrhœa that have come under my observation, I beg leave to offer the results as obtained from local treatment, believing that blennorrhœa, acute or chronic, can be more successfully treated by this means alone than by internal remedies, combined with the small injections usually prescribed. It is, however, important that the injections and insufflations, which I advocate, should be made by the physician himself, and no patient should be allowed to have a syringe and use injections indiscriminately.

The plan of treatment adopted was as follows: A good fitting suspensory bandage was first applied, the bowels were kept regular by a saline cathartic; stimulating food and liquors were to be avoided. A copious warm medicated injection of about three pints was used every day, sometimes twice a day, and always after urinating. A large flask, containing the fluid to be injected, was suspended above the patient's head, and a No. 2 catheter, warmed and well lubricated with vaseline, was connected to the flask by several feet of small rubber tubing, the catheter was gently passed down to the prostatic portion of the urethra, and the fluid allowed to run slowly out. After the tenderness had somewhat subsided, or when the discharge had lasted some time, a greater pressure was used, by placing the flask at a higher level, and so distending the urethral canal and allowing the fluid to come in contact with the whole surface.

I have used, with equally good results, solution of chlorate of pot-

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ash and sulpho-carbolate of zinc, in the proportion of one to three grains to the ounce, and when the tenderness was very great, an anodyne, such as extract of opium or belladonna, was used in the injection. Even in those acute cases the careful introduction of the catheter with a warm anodyne injection gave great relief.

After the injection, I applied astringent powders to the urethra, by insufflation. A small glass tube, about nine inches long and of sufficient strength, was passed gently down the whole length of the urethra. This tube is connected by a short piece of rubber tubing to a wide mouth bottle through the stopper; then air is forced into the bottle, by a hand bulb, through another short tube, which also passes through the stopper, the strong current of air passing into the bottle and out through the long glass tube, carries with it a portion of the powder which the bottle contains, and is deposited in the urethral canal, as the tube is slowly withdrawn.

The astringent powders are composed of tannin and sugar of milk, charcoal or starch, in different proportions, to suit the case. In chronic cases, equal parts are used with good results. The duration of the disease, previous to the time of treatment, varied very much; for instance, twenty-six patients had had a discharge for a time varying from two days to two weeks, while fourteen varied from two to six weeks, and two patients of intemperate habits had had a discharge of two months; nineteen patients had gonorrhœa for the first time, eight for the second time, and fifteen had had it several times.

Three patients had suppurating buboes, when they applied for treatment; nine had chancroids; four had indurated chancres, which were followed by secondary syphilis. Thirteen patients had one or more strictures in the urethra.

Local treatment gave the following results:

Four cases cured in one week.
Three cases cured in ten days.
Seven cases cured in two weeks.
} Diseased for the first time, and from two to seven days before treatment was commenced.

Eight cases cured in three weeks.

Seven cases cured in four weeks.

Seven cases cured in six weeks.
Six cases cured in eight weeks.
} Complicated with strictures.

One patient, a fireman, neglected wearing his suspensory bandage, and had a swelled testicle, which was soon relieved by antiphlogistic treatment. All the patients followed their usual avocations, and were obliged to be on their feet during the entire time of treatment. If rest in the recumbent posture could have been employed, the cure would doubtless have occupied less time.

My limited experience in the treatment of gonorrhœa leads me to believe that it can be most successfully treated by the observance of the following points.

FIRST—The *personal supervision* of the treatment by the physician.

SECOND—The use of *copious*, warm, medicated injections, not to be stronger than three grains to the ounce.

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THIRD—The application of a suitable astringent powder, that will remain in the urethral canal for a sufficient length of time to cause a healthy action to be taken on by the mucous membrane.

The above treatment necessarily implies time and patience on the part of the physician, but I think the result will be gratifying to both himself and patients.

THE USE OF CHLORAL, SURGICALLY,*

BY

MAURICE J. LEWI, M. D.,

Resident Physician and Surgeon at the Albany Hospital.

And now, gentlemen, we go half-way with Mr. Lucas, and say: "What we can prove substantiates just about one-half of what you assert." Let it not be thought, however, by any of you that I am opposed to the use of this remedial, but to the contrary, I consider it one of the best local applications to ulcers, of the pharmacopœia, used with certain precautions and under certain rules, to which I shall now endeavor to call your attention.

FIRST—Have your solution 5 grs. to the ounce, ointment likewise. Experience has proven that if this proportion be not efficacious, chloral is of no benefit in any larger or smaller proportion; that is, if the ulcer do not respond to a 5-grain solution of chloral, it is certainly chloral-proof as far as healing is concerned, and injurious as to the system generally in larger quantities. In the proportion above mentioned, there are no ill-effects noticeable, and the uncomfortable itching, spoken of by so many writers on this subject, has, in the cases cited, been present but in one, and then to last but a short time.

SECOND—Apply by means of sheet or picked lint.

The soft, yielding character of the fabric allows granulations to sprout up under it, and in place of acting as a foreign body, actually takes the place of a scab, protecting the wound from the air, retaining perfectly the ointment or solution, as the case may be, and bringing the application directly in contact with the surface. In fistula, where healing from the base is desirable, it makes an excellent packing, keeping the lips of the wound from contact, at the same time allowing granulations to sprout up on all sides.

THIRD—Change dressing daily.

We have observed, in the use of chloral, that unless the dressings are changed daily, there is a great amount of unpleasant labor connected with scraping the ointment from the ulcer, which, if it remains on for a longer period than twenty-four hours, acts as a foreign body, and does harm instead of good; while with the solution applied by means of lint, this dries very soon, and the hardened lint also interferes with the favorable progress of the wound. Changing the dressings oftener than suggested can also be of little advantage, as the

* Read, before the Albany Academy of Medicine, January 7th, 1887.

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chloral undoubtedly retains its stimulating powers for that length of time.

FOURTH—Continue the treatment for only one week.

This last seems to us the most important point to be observed in the use of this drug in the treatment of wounds. The ulcer that has been awakened from its lethargy by the stimulating chloral, loses its power of responding out of habituation, and after a short time—never, however, less than a week—a stasis ensues, its sensibility to chloral becomes blunted, and instead of responding as at first in the form of healthy and encouraging granulations, the wound assumes an unhealthy appearance, the ulcer becomes indolent, and the good offices of the first week of its use are slowly but surely lost in the continued use of a now inert and possibly harmful drug.

HOSPITAL RECORDS.

ROOSEVELT HOSPITAL, NEW YORK.

Reported by W. B. BERRY, M. D., House Surgeon.

LIGATION OF FEMORAL ARTERY FOR POPLITEAL ANEURISM. LISTER'S ANTISEPTIC METHOD. SERVICE OF DR. MARKOE.

Robert Haskell, U. S., aet. 28, single, clerk. About one month ago patient noticed a certain pain and stiffness in the left knee joint, situated along the hamstrings. This pain was increased by exertion. Soon he noticed a swelling at the part hard and pulsating. It was about the size of an egg. His occupation has not called for any great muscular exertion, and he cannot remember having at any time strained the part. One week ago, while jumping from a car, he had sudden and severe pain in the joint, followed by rapid swelling. The limb below soon became œdematous. He went home, kept quiet, and the swelling did not increase. On admission, patient has a soft pulsating tumor in the left popliteal space. It does not seem to be clearly defined. Pressure on femoral artery does not seem to make any difference in size of tumor on pressure.

There is some œdema of the leg and foot. Pulsation in anterior and posterior tibial arteries not interfered with. Patient cannot move the knee without great pain; circumference of tumor seventeen inches.

Treatment.—Joint kept perfectly quiet by a bed of plaster of Paris and patient put on low diet: viz., two ounces of bread and two ounces of milk, three times a day, with two ounces rare beef at noon.

September 17.—Patient has no pain. The tumor remains about the original size, and it seems to be somewhat more hard.

September 18.—Given veratrum viride three drops, t. i. d.

September 20.—Weight of eight pounds of shot was placed so as to press on the artery, just above Poupart's ligament.

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September 26.—The pulsation is reduced in force but is not entirely stopped by the pressure.

September 29.—By changing the adjustment of shot bag, pulsation is entirely stopped, but the patient is unable to bear continuous pressure. There is some œdema of foot and leg. Low diet discontinued.

October 3.—Weight increased to ten pounds. There is still pulsation when the bag is removed, but it is decidedly diminished. Circumference of tumor seventeen and five-eight inches, showing an increase of five-eight inches.

October 5.—Unable to bear pressure of bag but very little of the time. Pain intense. Pressure discontinued at night.

October 8.—Attacks of acute pain; much œdema in foot and leg. Size of tumor increasing; now measures little over eighteen inches.

October 9.—Size, eighteen and one-half inches.

October 10, 3 P. M.—Patient under ether.

Ligation of femoral artery performed by Dr. Markoe, assisted by Dr. Mason. An incision two inches in length was made over the position of sartorius muscle, at about apex of Scarpa's triangle. The skin, superficial, and deep fascia being cut through, the sartorius muscle, covered by its sheath, came into view. The sheath was divided, and what appeared to be the femoral artery appeared to the inner side of the muscle. This proved to be the femoral vein, the artery being felt pulsating more externally and more deeply. The femoral artery was then fully exposed for a short distance, by pushing aside the tissues, with the elevator on end of scalpel, and the aneurismal needle was then passed from within outward without difficulty. The artery was tied with carbolized cat-gut, and the ends cut short in the wound. Hemorrhage was but slight and readily checked. Edges of wound were brought together with carbolized gut, and Lister's dressing applied over all. Operation was done under spray; at end of the operation all pulsation had ceased in aneurismal sac, which felt soft and fluid. Patient removed to ward.

6 P. M.—Patient out of ether; complaining of very severe pain. Given hypodermic Majendie, ten minims.

October 11.—Pulse, 120; temperature, 99½. Wound redressed; discharge slight. No sign of irritation about wound. Lister renewed.

October 12.—Lister renewed; wound looking very quiet; circulation in limbs seems good. Aneurismal sac feels firm, but there is as yet no returning pulsation.

October 14.—Two remaining sutures removed. There is complete primary union. Pulse and temperature nearly normal. No recurrent pulsation in the tumor.

October 19.—Lister's dressing removed. There is complete primary union. Sheet lint and simple cerate used. There is very much less œdema of foot. Tumor seems firmer and of less size; *seventeen and one-fourth inches.*

October 26.—Patient sat up for short time. Cicatrix of incision very small and sound, but little œdema of leg remaining.

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November 3.—Passive motion at knee joint made.

November 12.—Size of tumor *sixteen and seven-eight* inches. Motion at knee increasing.

November 25.—Tumor measures seventeen and three-eighth inches.

December 6.—Tumor measures seventeen and two-eighth inches. Freer movement at knee joint.

December 10.—Slight œdema of foot and leg still continue. Size of tumor sixteen and six-eighths inches; no pulsation, and motion at knee increasing.

December 12.—Discharged cured.

CONTUSION OF BACK AND CHEST.—PERITONITIS, DEATH.—SERVICE OF DR. SANDS.

Cornelius Cummings, United States, aet. 21; single; laborer. Patient was struck in back in the lower dorsal region, by barrel of cider, which fell down cellar stairway. The barrel also rolled upon him. On admission there is a mere contusion of back in lower dorsal region, with pain and sensativeness in left hypochondriac region. Some shock. *Treatment*—Rest maintained with morphia to relieve pain.

November 24.—Complains of much pain in abdomen which is sensative and somewhat tympanitic. Vomits green matter. Thoracic respiration, but is very restless. Pulse 108, temperature, 100°. Given sol. morph. sulph., U. S. P., one drachm every four hours.

November 25.—Still complains of pain in abdomen. Vomits but seldom. Bowels constipated since admission, with no movement.

November 26.—Appears better. Abdomen only sensitive in left hypochondriac region. Morphia is continued.

November 28.—Vomiting still continues, throwing off nearly everything. Complains of much pain and lies curled up most of time. Some peristaltic motion of bowels. Much flatus. Dullness over left hypochondriac region, which continues sensitive. Lower dorsal region of back at point of contusion still sensitive.

5 p. m.—Pulse 84. Temperature 100°. Respir. 22.

Morphia sufficient to keep quiet; ordered not to move the bowels or give injection. Given ice to relieve vomiting.

November 29.—Suffers much pain at night. Tympanitis continues, but vomiting has stopped. There is an increased area of dullness on left side; extending downward into left lumbar and umbilical regions. Fluctuation detected over this area of dullness, and hypodermic needle drew off a serous fluid, red in color and containing red blood corpuscles. No pus detected. Palpation detects fluid in abdomen. Morphia continued, with diet of eggs and spts. frumenti.

9 a. m.—Pulse 100. Temperature 99°. Respir. 16.

5 p. m.—Pulse 100. Temperature 100 2-5°. Respir. 20.

November 30.—Patient continues about same. Appears to suffer

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much colicky pain, but has not a depressed appearance. Pulse strong. Tongue moist. Vomiting has returned again, consisting of mucus and often what he eats. The area of dullness in abdomen gives an indistinct tumor.

Hypodermic of Magend., sol. morphia, eight minims, t. i. d., with one drachm doses of U. S., sufficient to keep down the respirations.

December 1.—Dullness in abdomen found to be descending, and now on a line with the umbilicus, and one and one-half inches to the left of it. It extends well up towards the ribs and into left lumbar region. By straining, patient had a small passage from the bowels to-day. Tympanitis continues. Vomiting better.

Urine.—Alk. 1026. Trace of albumen, uric acid, amorphous urates and traces of pus. Occasional trouble in passing his water, and silver catheter used.

8 p.m.—Pulse 136. Temperature 99 1-5°. Resp. 32. Vomiting has returned with much pain. Feels weak; pulse rapid and feeble. Morphia injections continued.

December 2.—Patient changed for the worse during the night. Appears in a state of collapse with profuse sweat and cold extremities. Pulse at wrist almost imperceptible. Given hypodermics, whiskey. Rectum cleaned out, and injections of beef tea extracts, one-half ounce to two ounces water, given; also milk and spts. frumenti, each one ounce. Vomits much of time. Tympanitis becoming excessive, but no œdema of lung detected.

6 p. m.—Pulse 108. Temperature 97 1-5°. Respir. 50.

Is evidently sinking rapidly.

8 p. m.—Patient died.

Autopsy.—Abdomen found to contain large quantity of bad smelling brownish black fluid; not purulent. Complete general peritonitis; the abdominal organs everywhere matted together by strong adhesions of fibrine and also everywhere united to the abdominal walls. The small intestine intensely congested and brownish black. The ascending and transverse colon gangrenous, with a rupture, (probably recent) two inches long, in the transverse colon just below stomach.

Slight effusion of blood in chest in cellular tissue over the heart in ant. mediastinum, also found post-pancreatic hæmatocele of large size, ruptured into peritoneal cavity.

ABOUT BOOKS.

A Practical Treatise on Materia Medica and Therapeutics. By Roberts Bartholow, M. A., M. D. New and Enlarged Edition. New York. D. Appleton & Co., 1878.

The appearance of a new and enlarged edition of this valuable work, in such a short time after the first, is the best and most convincing evidence of the favor with which it has been received by the

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medical public. We learn that no less than three editions were printed from the original plates, and all of these being entirely disposed of. Dr. Bartholow thought that a new edition, enlarged by the addition of facts and observations he has since been able to collect, would be acceptable to the profession.

The author has added new matter in various parts of the work, and in all portions has carefully revised it. New articles have been inserted on beverages, vegetable acids, picrotoxine, caffein, grindelia, heat, cadminum, cannabis Indica, guarana, phytolacca, digestion-ferments, cereum, cuca, pulsatilla, and ailantus.

The scope, character, and excellencies of the work, were so thoroughly canvassed in the reviews of the first edition, and the work itself is now so well known wherever science is cultivated, that perhaps anything that we might now say would seem stale and unprofitable. We can, however, add our testimony to that of others who have so highly commended the work. Indeed it is the very best one that could be put into the hands of the medical student whose time is necessarily somewhat limited. Prof. H. C. Wood's work, so admirable in most respects, has the great disadvantage that it is not suitable for a college text-book. We think no one will deny this fact who has carefully read it or tried to study it. The average student after reading an article will get up from his perusal with very confused, vague and unsettled ideas as to the action of the remedy he has been studying. The mass of facts presented is too much to be digested in the time that can be devoted to it. As a work of reference, however, it is superior to Bartholow's. The latter work, though, perhaps, it is somewhat more dogmatic, is concise, clear, and full enongh for the student and general practitioner for whom it was intended. The mind is not confused by such a variety of conflicting statements and experiments.

The therapeutical part of the work is no doubt superior to that of any other that has appeared during the last few years, and the author is careful to show in every instance, where it can be shown, how the therapeutical depends upon the physiological action of the remedy. Besides this, the author's long and well digested experience has enabled him to show, in very many instances, the best method of exhibiting the agent, and the number of excellent formulæ that he has given, is one of the most valuable features of the book. In fact, almost every page contains some excellent prescription which the author has found useful in his own experience. A proper knowledge of the details of prescribing is a most essential point in successful practice, and Prof. Bartholow has not neglected this part of his subject.

We can give the work no higher praise than by saying that in our estimation, taking it all in all, it is the best work in the English language for general use by the student and practitioner.

The work is published by D. Appleton, and this is sufficient to say that it is everything that could be desired, as far as publishing is concerned.

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THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY.

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EDWARD J. BERMINGHAM, M. D., and FREDERICK A. LYONS, M. D.

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LECTURES.

LOCALIZED BASAL MENINGITIS IN CHILDREN,

BY

E. C. SEGUIN, M. D.

GENTLEMEN.—I desire this afternoon to call your attention to a class of cases in which the use of the ophthalmoscope is strikingly advantageous, and this in the hands of those not *expert* in the handling of the instrument.

CASE I.—This little girl, aged six years, was brought to my class at the Manhattan Hospital, a couple of weeks ago, with the following simple history. For two or three weeks, she had complained of headache, had vomited frequently, and on February 9, (a week ago,) internal strabismus appeared. The patient has not complained of impairment of vision, she has not had fever, spasm, or delirium. Constipation has, however, been marked. She is anæmic looking; a small brother of her's probably has phthisis, and one child of the same parents is said to have died of "brain fever." My assistant at the

A Clinical Lecture delivered at the College of Physicians and Surgeons, New York, Saturday, February 23, 1878.

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Manhattan Hospital, Dr. Adam, immediately examined the child's eyes with the ophthalmoscope, and found double neuro-retinitis: a diagnosis which I concurred in, and which was verified by Dr. Webster in the Ophthalmic Department of the Hospital. Consequently, the most important symptom was the one revealed to us by the use of the ophthalmoscope. I made the diagnosis of basal meningitis localized about the chiasm of the optic nerves, probably without tubercular deposit. The child was blistered behind the ears, and given ten grains of potasium iodide, three times a day, with instruction to increase the dose by five grains per dose, every second day.

As you see the child now, she does not seem sick, and were it not for the convergent squint, you would probably consider her as only a delicate anæmic child. In the last few days, the headache and vomiting have ceased, and improvement has begun.

I shall now relate two analogous cases from my private practice.

CASE II.—Referred for examination to Prof. H. Knapp, on May 2, 1877, a girl, aged four years, previously healthy. First symptoms noticed about five weeks before examination, consisting chiefly in dullness, irritability, slight headache, and, on one occasion only, vomiting. Two weeks later internal strabismus (one eye) suddenly set in, and has persisted. No fever, spasm, or delirium. Previous to this attack there had been no emaciation, or cough, or ill-health of any kind. Dr. Knapp found double neuro-retinitis, with paresis of external rectus of one eye. On examination, I found the child with the above optic symptoms, and very cross; the buccal temperature was 99° F., and the pulse 96, perfectly regular. I made the diagnosis of non-tubercular localized basal meningitis, and expressed the opinion that the child's life was in no danger, though vision might remain considerably impaired. Dr. Knapp was giving potassium iodide, which I also advised. A few days ago Dr. Knapp informed me that a few weeks after I saw the child the strabismus disappeared, and that the neuro-retinitis gradually gave place to atrophy of the optic nerves, which, fortunately, was but slight, so that vision is now nearly perfect.

CASE III.—Sent me for examination by Prof. C. R. Agnew no February 14, 1878. I learned that the patient, a little girl five years old, had gone through an attack of chicken pox, early in January, without fever or apparent ill-health. About January 19th, the left eye "turned in," and strabismus has been constantly present since. No other symptoms have been observed—no fever, headache, irritability, etc. The mother states that one of her former children, at the age of eleven months, had convulsions and fever, became unconscious, and died in two weeks.

Examination of the eyes by Dr. Agnew reveals "double optic neuritis, with some stuffing of the discs; hypermetropia one-seventh of each disc."

I made the same diagnosis as in the second (first in point of time)

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case, viz.: local basal meningitis, of non-tubercular nature. Advised blisters behind the ears, and large doses of potassium iodide.

These three cases illustrate a form of disease which is not, to my knowledge, treated of in the text-books, yet one which I suspect is not very rare, and which the more general use of the ophthalmoscope would render yet more common. Without a view of the fundus of the eyes in these little patients their trouble would have seemed strange or trivial. For, consider how few symptoms they presented.

Headache was present in two of them, and was frequent or severe only in one.

Vomiting occurred frequently in one child; only once in *Case II*, and not at all in *Case III*.

Irritability and change in disposition, (a real symptom in children under many circumstances,) occurred in only one child.

Strabismus occurred in all, and was, in reality, the only symptom which alarmed the parents, and caused them to seek advice. In *Case II*, Dr. Knapp expressly states that he found paresis of one external rectus; but in *Case I* the muscles seem fairly strong, and it has occurred to me that, perhaps in these cases, the squint is due to a stronger accommodative effort which the child unconsciously makes to obtain better vision, as in the squint which accompanies hypermetropia. In *Case III* there was hypermetropia of one-seventh.

Neuro-retinitis was present in all the cases. Such important symptoms of intra-cranial disease as *convulsions, delirium, paralysis, fever, irregularity of the pupils*, and of the *pulse-rate*, were absent in all the cases. In none of the cases was the basal disease secondary to any serious general fever or constitutional state.

The condition of the optic nerves and retina found in these cases is known as neuro-retinitis, or choked discs. In this state, the optic nerves appear swollen, and may project considerably (measurably) above the level of the surrounding retina; the margin of the disc is obscured or wholly lost, and no line of demarcation can be made out between the nerve and the retina. The blood-vessels present striking anomalies, the arteries being relatively small, the veins positively large and tortuous; there are often small hæmorrhages in the retina, round about the disc. This condition of choked disc may last a number weeks, (much longer in cases of tumor of the brain,) and then subside, giving place to the appearances of atrophy of the optic nerves, viz.: an unnatural whiteness, or bluish-whiteness of the disc, smallness of the retinal vessels, and unusual sharpness of the outline of the disc. A degree of atrophy must be looked upon as inevitable in the stage of recovery in cases such as those related above; hence we must be cautious in prognosis *as regards vision*.

I would next invite your attention to the probable seat of lesion in these cases, and the mechanism by which choked disc is set up. At the base of the brain, anterior to the pons Varolii, and between the two temporal lobes, is a vast reservoir of subarachnoid fluid, contained in the meshes of the pia-mater, in the so-called anterior sub-

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arachnoid space. Within this space lie the chiasm of the optic nerves, the roots of the olfactory nerves, and the trunks of the third, fourth, and sixth nerves, on their way to the orbit. Each of these nerves, but more especially the optic, has a lymphatic circulation of its own, within its sheath, and in communication with the sub-arachnoid space. In reality, the same fluid which fills up the anterior sub-arachnoid space circulates in the lymphatic spaces of the optic nerves as far as the eyeball. When inflammation occurs at the base of the brain, or when a tumor is placed there, there is, of necessity, produced a retardation in the two circulations of the optic nerves—their blood circulation and their lymph circulation—and in consequence blood and lymph accumulate in the head (or retinal end) of the nerves, the arteries are small, the veins enlarged, and some of these may burst. Thus may all the optic phenomena of basal meningitis be explained. But, besides, more active processes, exudation, and migration of leucocytes may take place in the delicate optic structures, and result in serious mischief. The effects upon the motor nerves are readily explicable by the same mechanical causation; but it is a little difficult to understand why the sixth nerve, which is certainly more robust than the fourth, should alone suffer. That is, upon the supposition that paralysis is actually present, and that we have not to deal with an accommodative squint.

We ought, with such a lesion so placed, to have some impairment in the function of smell. This is an interesting point which has not yet been investigated, I believe.

I have spoken of meningitis and tumor as giving rise to choked discs, and it may be well for me to say why I do not believe that tumors are present in these cases. *First*—Tumors of the basis are rare in children; they generally have intra-cerebral or cerebellar tumors of the tubercular kind. *Second*—A basal tumor will give rise to more positive paralytic symptoms than are present in our cases; either decided palsy of one or more cranial nerves, or weakness of the limbs on one side. *Third*—Convulsions would form a prominent feature in the symptom-group.

While regarding the lesion as an inflammation of the pia mater, I do not believe that it is tubercular, because of the absence of aggressiveness on the part of the disease, the absence of previous sickness, or of focus whence tuberculization might be set up; and, lastly, because in one case recovery easily and rapidly occurred.

As to treatment, I would advise iodide of potassium in doses varying from ten to sixty grains three times a day, well diluted. These little ones bear the iodide wonderfully well, when it is gradually increased. Counter-irritation has some effect at first, and I would place the blisters behind the ears or on the temples—quite a series. At the same time I would give the child light but nutritious diet, keep it quiet, and avoid everything which produces determination of blood to the head, as active play, anger, surprises, etc. There is no need, I think, of confining the patient to the house.

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Finally, gentlemen, I am pleased to speak to you of these cases, in order to give you faith in the value of the ophthalmoscope in the hands of the non-expert. I do not ask you to believe in the diagnosis, by any but our best oculists, of delicate lesions, such as slight anæmia or hyperæmia of the fundus of the eye, or faint atrophy of the optic nerves; but you, and all practitioners, should be able to recognize a fairly normal optic disc and retina, and to distinguish such gross lesions as choked discs, hæmorrhage of the retina, and marked atrophy of the optic nerves. I trust that before you enter upon the practice of your profession, after finishing the elementary curriculum of the winter, you will seek private instruction in the use of the ophthalmoscope, and thus arm yourself with a weapon which will enable you to do more good, to improve your reputation by correct diagnoses, and, what is often more advantageous, to avoid damaging that reputation by an unfounded favorable prognosis in cases such as these, in which all signs, except the hidden ones, are not serious.

CLINICAL LECTURE ON THE FORMS OF DYSPEPSIA AND THEIR TREATMENT.

Delivered by WILLIAM PEPPER, A. M., M. D.,

At the University Hospital, Philadelphia.

CASE I.—P. Mc., forty-seven years of age, a laborer, had malarial fever some twenty years ago, with derangement of intellect. Has lately been in the habit of tending brick-kilns for thirty-six hours at a time. Swells up after eating, feels drowsy and heavy, and belches wind. These spells come on at any time. His tongue is large and flabby, and its papillæ are enlarged. The man has not indulged in any intoxicating drinks for the last ten years, but still smokes a great deal, and drinks three large bowls of coffee daily. You will meet with a great many cases of this kind in your practice. There are very evidently two elements which we have to deal with here—(1) torpor of digestion; and (2) very marked sympathetic nervous disturbances. The dyspepsia may result either from the fact that the food merely goes through the stages of digestion slowly, and so ferments and evolves gas, or it may come from a defective supply of gastric juice, or from defective peristaltic action. In other cases there will be marked nervous disturbances. These are very marked in the present instance, and may therefore coexist with the gastric symptoms. The man has gastric vertigo, headache, and neuralgic pains.

The man has evidently brought on this condition by his constant exhaustive attendance upon the brick-kilns and by his overuse of tobacco. Indeed, his symptoms are just those which we would expect to find in a case of chronic tobacco poisoning. The patient must be put upon a very careful diet of skimmed milk, from two pints up to

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two quarts daily, must give up his coffee and tobacco altogether, and, if possible, change his occupation, for the present, at least.

CASE II.—The patient was a car driver until two years ago, when he gave up that business and became a night watchman. Three or four years ago he was frequently intemperate. He also chewed a great deal at that time, and drank much coffee. His sleep was insufficient, and his work hours were from six in the morning until after twelve at night. He has suffered from much the same symptoms as *Case I.*

Nearly all cases of dyspepsia have some well defined cause. You see at once what the cause has been in this instance. We cannot have, as physicians, too clear ideas of the action of certain substances. The baneful effects of intemperance upon the coating of the stomach are too well known to need mention. My constant, every day experience is proving to me that in the immoderate use of tobacco, coffee, and tea, we have another most fruitful source of dyspepsia and nervous derangements. When taken into the stomach several times daily, and in large quantities, they make the nerves of the stomach more sensitive, and increase the amount of the gastric juice, rendering it much more liquid and watery in consistency, and diminishing the proportion of pepsin. They also act as sedatives to the muscular wall of the stomach, thus impairing its power of peristalsis, and producing, when absorbed, a state of nervous hyperæsthesia. Tea and coffee in particular, when taken upon an empty stomach, are exceedingly injurious. None of these three articles in overdose make people violent; but they cause just as much unhappiness as does alcohol when taken immoderately. Just as there are many grave diseases following chronic alcoholism, so the overuse of tobacco, coffee, and tea gives rise to a horrible amount of functional disturbance.

I repeat, therefore, my statement made above that very many cases of dyspepsia depend upon the excess of some particular article of diet, joined perhaps, as in the present case, with some irregularity of meals. How must such patients be treated? In the first place this man must give up absolutely his tobacco and coffee, and place himself upon a plain diet. His stomach is weak, its muscular action impaired, and its nerves over-sensitive, giving rise to reflex disturbances, such as giddiness and palpitation of the heart. Our patient must not take much food at a time into his stomach. The best diet for him will be one of skimmed milk—one-half pint every four hours.

* * * * * * * * * * *

Our patient comes back to us to-day, showing the excellent results of our treatment. He has given up tobacco and coffee, and has not touched a morsel of solid food since you saw him last, and has not had a single attack of pain or indigestion. Sometimes milk is not well digested, when such is the case, I generally combine lime water with it. I begin with three ounces every two hours, then four ounces every three hours, until as much as three pints is taken in the course of the twenty-four hours. Another sovereign article of diet is butter-

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milk. In buttermilk the casein of milk is coagulated and broken up so that the stomach is spared two steps of the regular process of digestion. Still another, excellent preparation of milk is koumyss. This is now made in America. It contains a good deal of carbonic acid. Milk is mixed with brewers' yeast, then corked and put on ice. Koumyss is a sparkling drink, very sedative and palatable.

Among drugs, arsenic, in small and gradually increasing doses, is a remedy of extreme importance.

I have found the following prescriptions of great use in certain forms of dyspepsia:

(1.) Sodæ bicarb., three drachms; acidi hydrocyani dil., forty-eight drops; tinct. valeriani, one ounce; syrup zingiberis, two ounces. Misce. Sig. a teaspoonful, thrice daily, in water.

(2.) Quiniæ sulph., sixteen grains; strychniæ sulph., one-third grain; acidi muriat. dil., one and a-half drachms; syrup zingiberis q. s. ad., four ounces. Misce. Sig. two teaspoonfuls in water, right after meals.

This is a case of flatulant dyspepsia, with impaired digestion and considerable accumulation of gas. There has been no coffee or tobacco poisoning in this case. The man is a sailor, forty-two years of age. For the last five months, he has suffered from gastric vertigo and slight pains after eating. His bowels are costive. The epithelium of his tongue is rough and its papillæ enlarged. Bread and tea do not affect him, but anything greasy does. Last spring he was in bed seven weeks with typhoid pneumonia, and dates his dyspepsia from that time. Here you see that the dyspepsia has been brought on by a prostrating illness.

The treatment in this case is very simple, for there has been no grave error of diet which needs correcting. We must make the stomach's work lighter by placing the patient on a carefully selected diet. This is very hard to do in the case of patients in this class of life. Such patients have to take what is put before them, or nothing at all. I will tell the man, however, to avoid heavy foods, fried foods, sweets, pastry, rich pudding. His diet should consist of such articles as eggs, milk, starchy vegetables, stewed fruits, a little butter with stale bread. After meals, I would advise him to take a ten grain pepsin powder, or better still, a couple of teaspoonsful of prescription No. 2—(see case II.)—thrice daily, after meals. I say right after meals, for we want this recipe to be taken in the acid and not in the alkaline stage of digestion. Where there is marked hepatic disturbance, the following prescription is an excellent one:

(3.) Muriat. acid. dil., one-half drachm; tinct. nuc. vomicæ, one-half drachm; comp. infus. gentianæ, q. s. ad., four ounces. Misce. Sig. a dessert-spoonful after meals in water.

(4.) Also the following: Bismuthi subnit., one and a-half drachms; pepsin., one and a-half drachms; strychniæ sulph., one grain; tinct. cardamomi comp. q. s. ad., four ouuces. Misce. Sig. a teaspoonful, thrice daily, in water. If there is much flatulence, increase the

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amount of bismuth and pepsin; if the case is merely one of gastric atony, increase the amount of strychnia.

CASE IV.—The patient is an hostler, thirty-four years of age, and married. Has suffered from fullness in the stomach after meals since 1865. For the last seven months has complained of severe shooting pains in the pit of his stomach. These pains extend through to his back and up to his shoulder blades. His bowels have always been costive. The pains in his stomach come on about three hours after meals. The pains are relieved temporarily by eating, but come on again with renewed vigor. Has palpitation of the heart after any excitement. Occasionally has spells of giddiness. Urine is normal.

What is the cause of this man's attacks of gastralgia? There is no gastric ulcer, for the pain is not localized, and there is no vomiting and no hematemesis. There was, no doubt, originally some subacute gastritis which passed away, leaving behind a chronic gastralgia. This gastralgia follows the ordinary law. The pain comes on at the close of digestion, because the ingesta are then acrid and fermenting. The spells of pain last as long as there is any acrid matter in the stomach. This man has, therefore, a state of slow digestion, complicated with a pure neuralgic condition of the stomach.

I find that he is at present very careful as regards his diet, but that two or three years ago, he used a great deal of tobacco, and drank a large quantity of coffee daily. His occupation at that time was a most exposing one.

I will tell this patient to limit his diet to a gill of skimmed milk every two, or three hours, at first, then a-half a pint six times daily. He must also take from two to five drops of Fowler's solution when the paroxysm of pain overtakes him. Prescription No. 1—(see *Case II*)—will be of great benefit to him. If the Fowler's solution does not control the pain, let him use over the epigastrium, first, a blister two inches square, then a belladonna plaster six inches square.

CASE V.—This man has dyspepsia, urticaria, and post-nasal catarrh. He is a miner, and is at work in the mines ten hours daily. He has suffered from attacks of hives for the past four years. For over a year he has had the post-nasal catarrh. There is plenty of yellow, thick phlegm in his posterior nares, his appetite is irregular, his tongue thickly coated, his bowels either very costive, or very loose, and his urine high colored.

Upon examining the man's throat I find a red, swollen mucous membrane on each side of the pharynx. The post-nasal space is filled with a purulent discharge.

Urticaria is one of the most obscure and interesting of cutaneous affections. It is generally sympathetic of some digestive or nervous derangement. The effusion under the skin is usually reabsorbed by some reflex mechanism when the source of irritation is removed. While the eruption lasts, the burning and itching are intolerable. The urticaria has brought on a state of increased sensibility of the

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mucous membrane of the throat, stomach, and intestines; a sort of confluent catarrh of the alimentary canal.

Treatment must be twofold—(1) The diet must be regulated. Milk is the best food. This man had better use prescription No. 3. If his bowels are costive I shall order some laxative—some sulphur with molasses, or put up with confection of orange, or given in wafers. (2) As a local application for the throat I would advise iodine, or, better, nitrate of silver. The brush by which this latter salt is applied must be so arranged that it can be touched to both of the nares separately. We must insist upon it that our patient give up his habit of constantly hawking and spitting.

[The man has now been under treatment three weeks. He has made very marked improvement in that time. His dyspepsia is all gone, and there has been no eruption of hives since you last saw him. The catarrh is gradually getting well.]

ORIGINAL ARTICLES.

FAULTY INNERVATION AS A FACTOR IN SKIN DISEASES,

BY

EDWARD WIGGLESWORTH, M. D., BOSTON,

Dermatologist to Boston City Hospital, and Instructor in Syphilology at Harvard University.

Delpech, as early as 1832, (*Revue Med., vol. i,*) called attention to the existence of nerve lesions due to compression from contracting cicatricial tissue. Hamilton (*Archives Gen. de Medecine,* 1838, t. ii) states that with pain, redness and swelling may occur in parts at a distance from the original injury, though in the course of the nerve, resembling the effects of a sub-aponeurotic abscess, and increasing and diminishing abruptly and even periodically.

Thus, Obs. I. and III., where wounds of the hand were followed by periodical swellings, limited to the regions of the nerves affected, and accompanied by pain and greatly increased action of the sudoriparous glands, these swellings disappearing as suddenly as they came; and Obs. IV., in which there was in addition a morbid production of hair.

Professor J. Roux (*Gaz. des Hop.*, 1840, p. 101) reports a case where a nervous filament was injured as the result of venesection, the consequent swelling being strictly limited to the parts appertaining to the injured nerve, namely, the thumb, index and medius fingers, which became also very sensitive to heat and cold. The importance of these swellings, in a diagnostic point of view, is insisted on by Remak, (*Œsterr. Zeitschr. f. prakt. Heilkunde,* 1860, No. 48.) Romberg (*Lehrbuch,* 1851, vol. i, p. 232) adds to these other results, such as diminution of calorification; inability of the part affected to withstand changes of temperature, cold water causing bullæ at the ends of

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the fingers, a fact observed also by Dieffenbach in regard to portions of skin transplanted in plastic operations; livid color due to stasis of capillary circulation. Similar observations have been made by Brown-Sequard, and especially by Charcot (*Journ. de Physiol.*, 1859). So, also, by Samuel, (*die trophischen nerven*, Leipzig, 1860,) by Paget, (*Medical Times*, 1864,) and by Weir Mitchell, Morehouse and Keen, (*Gun-shot wounds, and other injuries of the nerves;* Philadelphia, 1864.)

Of the cutaneous affections due to traumatic injuries of nerves, some may appear in the peripheral region of the nerve injured, others at a distance and upon parts supplied by nerves which have undergone no injury. The latter class must be attributed to reflex action. That an actual neuritis exists in such cases, is shown by the experiments upon animals of Descot, (*These de Paris*, 1822, No. 233,) and Dubreuilh, (*These de Montpellier*, 1845, No. 34,) by Vulpian and Tillaux, (*These d'agregation de chirurgie*, Paris, 1866,) and by Eulemburg and Landois, (*Gaz. Med. de Paris*, 1865.) Mitchell, Morehouse and Keen, in their work, based upon observations made during our recent civil war, divide the result of nerve lesions into four groups, the second being the alterations of the skin. Here there is generally at first œdema, the skin then becoming dry, thickened, yellowish or brown, and scaling off, while the nails become curved and thickened. The erythema, described by Paget, they have observed nineteen times out of fifty cases of partial lesion of the nerves, and Mougeot (*Recherches sur quelques troubles de' Nutrition consecutifs aux affections des nerfs*, Paris, 1867,) considers one of the essential conditions of its existence to be a merely partial separation of the nerve from the nervous centres. He adds, that when a single nerve is affected, as, for example, the median or the cubital, the erythema only exists in that part of the skin where its final ramifications are distributed. Vesicles or bullæ, followed by ulceration, may also occur, and ulcerations, consecutive to compression of the median nerve and its irritation, appear and disappear, cicatrize or remain stationary, according as the patient, by the position of the limb, maintains or removes the compression and consequent irritation. Such a case is reported by Charcot, (*loc. cit.*, vol. ii, p. 108.) Earl, in Romberg, (*loc. cit.*, p. 16,) reports a case where redness and pemphigoid bullæ appeared several times consecutively as the result of an injury of the external cutaneous nerve by the thrust of a fork. Mougeot (*loc. cit.*, p. 41) mentions a case, reported by Gosselin, of ulcerations upon the palmar aspect of the middle and upon the extremity of the index fingers, resulting from incomplete division of the median nerve. Also one of Paget's cases, in which the radial and median nerves of a child, aged eleven years, were completely divided by a circular saw, and at the end of a year sensation had not returned to the last phalanges of the thumb and index finger, the parts chilling readily, and large bullæ forming upon the hand. In his *Surgical Pathology*, vol. i, p. 43, Paget reports a case of compression of the median nerve, followed by ulcerations, appearing or

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disappearing according to the presence or absence of irritation due to this compression.

Weir Mitchell, (*Injuries of the Nerves and their consequences*, Philadelphia,) after alluding to Hutchinson's series (*Clin. Lectures and Reports*, London Hospital, 1866,) of injuries from cutting, mostly by glass, where loss of sensation and motion were serious and lasting, and with marked nutritive changes, quotes such a case, where division of the ulnar nerve and vessels, and of the median nerve, was followed by anæsthesia of the parts supplied, inflammation of the tips of three fingers unattended by sensation, and diminution of animal heat in all the parts paralyzed. At the extremity of the middle finger, was formed a subcutaneous bulla, the cuticle being elevated by effused serum, (subcuticular whitlow,) with a red areola.

He states, also, that there is no absolute physiological proof of the existence of trophic nerves; but, in the phenomena of nerve wounds, there are certain arguments in favor of the possibility of disorders of nutrition being capable of production by the irritation of ordinary nerves of sensation, and, indeed, of motion.

Létiévant, (*Traite des Sections Nerveuses*, Paris, 1873,) considers trophic changes as most prone to follow wounds of nerves which are distributed to the hands and feet, and as more rare after injuries to nerves supplying the upper portions of a limb.

Peripheral changes might, therefore, be anticipated after injury of the median nerve of the arm, which supplies tactile sensibility to the palmar surface of the hand, as in the following case:

M. O'B., of New Brunswick, an unmarried seamstress, aged forty-three years, applied to the Boston Dispensary for Skin Diseases, October 2d, 1874. About two years previously, she had injured the tissues over the second joint of the right thumb by falling with her whole weight upon the joint, while her hand was tightly clasped, thus cutting a deep gash upon its radial aspect, which now shows a ragged cicatrice.

On January 1st, 1874, the tissues of the last phalanx became tender, the skin grew hard, "like a corn," and peeled off. Tincture iodine was applied, causing great pain. Rubber cots were used to no purpose. In September the ball and end of the thumb festered. For this she desired treatment, as she was unable to pursue her trade of sewing coats.

October 2d, 1874, the whole last phalanx of the thumb is red and swollen, hot and tender to the touch, smooth and dry. Voluntary motion somewhat interfered with, but no spasms nor contraction. The joint proper does not appear to participate in the process. At the upper portion of the palmar aspect of the thumb are two small pustules, hardly raised above the level of the surrounding skin, and covered by a thick cuticle. These, when opened and poulticed, would scale off. Under diachylon ointment things would apparently improve. Then, with pains extending up the arm to the top of the shoulder, the whole process would repeat itself. Fearing that the median nerve had been, perhaps, crushed at the time of the injury to the thumb, and seeing

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that the lesion hardly fell within the domain of dermatology proper, I requested Dr. J. J. Putnam to see the case, October 28th. He galvanized the thumb at intervals until April 14th, 1875, the patient continuing iron internally, and belladonna plaster externally. She derived so much benefit that she ceased attendance at that time. March 4, 1877. She again asked relief. Pustules like the others were again present, the ball of the thumb was painful and quite sensitive to pressure. There were also tender spots upon the palmar sides of the joints of the first and second phalanges.

The skin of the ball of the thumb was thickened, except where the festering process had just been completed; there it was thin and of a glossy red color. Drs. D. F. Lincoln and S. G. Webber saw her at this time, the latter gentleman being also kind enough to administer a six weeks' course of electricity. The patient then again disappeared.

November 9th, 1877. Patient has returned. The condition much as in March. Whole thumb enlarged and reddened, painful pustules all along, and under the free end of the nail and the nail itself being hard and dead, thickened, and of a yellowish brown color. The pustules make their appearance within twenty-four hours, then, in from twenty-four to forty-eight hours, they dry and scale off. The interval between this scaling and a new formation of pustules was formerly one of weeks; but now, practically, does not exist, the crops being continuous.

Under Dr. Putnam, treatment by electricity was recommenced, the woman's thumb being placed in a basin of water alongside of the negative pole of a galvanic battery, the positive pole having been put either at the back of the neck or on the arm, and as strong a current used as could be borne; this at intervals of a few days.

Early in January, 1878, a pustule formed, for the first time, at the root of the nail, underneath it, accompanied by sharp pain and softening of the nail, which, after the absorption of the pustule, began to grow very fast; probably a good effect of the galvanic treatment.

January 23d, 1878. During the last fortnight the ball of the thumb has been six times superficially cauterized with the gas cautery, the skin having previously been frozen with ether spray. No special improvement was, however, noticed from this stimulation. Galvanism has now been employed since November, and under this the pains passing from the thumb along the front of the arm to the top of the shoulder have diminished, and occur only at night. So, also, the pain in the end of the thumb is present only at night, and then only during an access of the festering process. Internally, the patient takes Fowler's solution, three drops ter die; and is "of the decided opinion that the thumb has done better during this treatment" by galvanism. She is able, already, to do a certain amount of sewing, and, although the ball of the thumb has become flabby, this appears to be due rather to absorption of subcutaneous tissue, than to actual atrophy of the muscles.

February 4. Nearly well.

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In a case reported, (*Berliner Klin. Wochenschr*, 10 Sept., 1877,) by Dr. W. Sander, of Berlin, of "Trophic disturbance following injury to the left median nerve," this nerve was injured by a cut four centimetres in length across the lower arm, a little above the styloid processes of the radius and ulna. Six flat, whitish, oval vesicles soon appeared, two being upon the thumb, two upon the index, and two upon the middle finger. They were from pea to bean size, and their contents, at first clear, soon became turbid, after which the vesicles dried to a scab and fell off, leaving cicatrices, which seem to form regardless of the absence of innervation. There were present in the fingers weariness, stiffness, immobility, numbness with pricking, and loss of tactile sensibility; the skin was flabby, red and smooth, and did not perspire. No change occurred in the nails while the patient was under observation. In this case the vesicles appeared in succession, the first being noticed as early as ten days after the wound, and the neuritis must be regarded as an acute process.

We may also regard this case as one of complete section of the nerve, whereas in my own the section was probably partial; for, according to Létiévant, (*loc. cit.*,) complete section of the median nerve causes immediate anæsthesia and paralysis, and eventually muscular atrophy and deformity; and Mitchell (*loc. cit.*) shows that, while, when nerves are wholly divided, blows or pressure may cause readily-healing ulcers; where nerves are partially divided, bullæ and superficial ulcers may appear, apparently without cause, assuming the form of the "sub-cutaneous whitlows" of Hutchinson, and painful or not, according as they occur in anæsthetic or hyperæsthetic regions. So, also, excessive and even bad-smelling perspiration, especially where neuritis is present; though later, where there is loss of function from atrophic changes, both oleaginous and sudoriparous glands may cease to act.

Assuming, then, that the local manifestations in my case arose from partial section of a branch of the median nerve, are we to regard them as due to direct or reflex irritation?

Mitchell (*loc. cit.*) quotes Daniellsen and Bœck as stating (*Recueil d'observations sur les Maladies de la Peau*, Christiania, 1860,) that in the anæsthetic form of leprosy the nerves undergo certain changes, propagated finally from periphery to centre, causing at first neuralgia, tingling and hyperæsthesia, which become intense, followed by anæsthesia and loss of motion as from gradual compression, the earlier symptoms being related to simple congestion of the neurilemma, the latest to a hyperplasia of the connective tissues within and without the nerve sheath, causing compression of the nerve fibres, and extinction of their functional life. He adds, that nerve-wounds may attack the cutaneous nutrition directly by irritation of fibres leading to the part, or reflectively, through the centres and by uninjured filaments upon the skin. He has seen a sudden accession of inflammation in a healing wound over the injured median nerve determine an immediate outbreak of neuralgia, ulcerated matrices of nails, and vesicular erup-

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tion. Now, as we can hardly hold that the injured nerve was suppurating and exuding through the skin at its peripheral termination, like the dead nerve of a tooth through the gingival tissues, it seems fair to conclude that certain cells of the posterior cornua of the spinal cord were affected by transmission of irritation from the periphery, and that these cells again caused the actual tissue-changes in the tissues at the distal terminations of the nerves connected with these cells. In this connection, the following case is of interest:

J. M., aged forty years, shoemaker, applied to me, December 22d, 1873. In 1846, a knife was plunged into his left arm, along the inner aspect of the biceps muscle. It was seventeen weeks "before he could lift a teacup." Scar now present. In 1853, while holding a one-and-a-quarter-inch drill, a piece, an inch long, was split off and driven through his hand, between the metacarpal bones of the thumb and forefinger. Scar plain to-day. September 1st, 1872, a horny patch was noticed upon the ball of the thumb, as if this "had been burned by a hot iron." The thumb swelled, and after four days, deep fissures had formed across the ball, which was so sensitive as to prevent him entirely from working. He received the very best treatment for eczema without effect, and subsequently passed through the hands of various physicians, and, finally, of vacuum-pumpers, mesmerizers, and quacks of every description. Recently there appeared upon the ball of the thumb a blister of the size of a large bean. This he punctured, and its contents oozed out "as thick as molasses, and nearly half an inch high, and coagulated, as transparent as glass." This being washed off, the cut healed in four days; but in less than a week another smaller blister appeared, and when punctured, exhibited the same results, but took two weeks to heal, with a little watery running during this period.

At present there are horny patches, resembling those of old eczema, upon the ball of the thumb and upon the radial aspect of the tissues covering the metacarpal bone and the first phalanx of the fore-finger. On the thumb, the old skin was cracking off and new skin appearing. Pain on deep pressure. Whole thumb atrophied. The nail of this thumb was smaller and more rounded than that of its fellow. Cold is more readily and sharply felt in this thumb than in any other part of the body. Light superficial cautery was used, followed by diachylon ointment, until February 8th, when Dr. J. J. Putnam was kind enough to employ galvanism, the positive pole being placed over the palmar surface of the thumb, the negative over the median nerve at the wrist, and later over other portions, and over the vertebral column. Improvement very marked for several weeks, the nail growing also quite rapidly.

February 26. Dr. Putnam tells me that for the last two days there has been less improvement. The soft parts of the thumb are much swollen, the skin dry and shining, great itching, and last night tingling sensations up the arm on the inner side and in the elbow-joint. The nail continues to grow well. The patient describes this as the

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usual course of an attack, but that after twenty-four to thirty-six hours, the swelling begins to diminish, leaving the skin loose, hard and devitalized, and this then cracks and is thrown off. Gradually the end of the thumb shrinks to half its natural size. So it proved here; after which improvement was again manifested, though the fleshy parts of the thumb remained unnaturally soft; and within a fortnight the patient reported himself as "cured." A relapse, however, occurred, when he was given arsenic internally; and, externally, superficial cautery with a caustic potassa solution every second day, and was again treated by Dr. Putnam with electricity twice a week, until July, when he ceased attendance.

In August, 1877, I met him in Maine. Part of the intervening time, he stated, had been spent in an hospital for the insane. He considered that "electricity had cured" him. In January, 1878, he made the same statement upon calling on me, with his thanks, and upon Dr. Putnam with (most justly) a new patient.

In the cases under the care of Dr. Putnam and myself we are dealing with old injuries of nerves, consequent diminished powers of resistance on the part of the tissues supplied by these nerves, and continuous irritation of these tissues by external agencies of a mechanical nature arising from the occupation of the patients. On the other hand, Prof. J. S. Jewell reports, (*Archives of Dermatol.*, July, 1877,) cases which he regards as descending neuritis, which occurred immediately after impure vaccination by subcutaneous injection of old human virus, where the lesions, more peripherally situated than the point of inoculation, were upon tissues unirritated by external agencies.

In other cases, a morbid process, not traumatic, will cause reflex or sympathetic irritation at, apparently, as great a distance as possible from itself. Thus I have seen herpes labialis followed, in a day or two, by herpes of the anus, no other part of the body being affected. The reflex irritation of worms in the rectum upon the nasal mucous membrane has been observed by every one. There is at present a most interesting case under my charge, the explanation of the nature of which I owe to Dr. J. C. White. He has seen but few such cases. I never saw one before to my knowledge. In this, as in all of Dr. White's similar cases, vulvar irritation, in this case that of an old eczema, has preceded or been accompanied by a deep-seated and persistent dermatitis of the chin, the expression of a neurosis of reflex or sympathetic origin.

Or, again, the sympathy may be between the interior and the surface of the body. Thus a rosacea may be due to the frequent flushing of the face following heavy meals. An acute gastric catarrh will often be accompanied, or immediately followed, by an acne composed of miliary pustules, which dry up and scale off as the gastritis passes away. Inversely, a cold, wet cloth applied to the forehead often causes, almost at once, the vomiting necessary to relieve the sick headache of indigestion. Urtricaria resulting from indigestion is only too common, and cases of alternating asthma and eczema are not very rare.

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But the nerves, or their ganglia, may not merely transmit a morbid influence; this may originate with them, as has been thoroughly shown in many cases of zoster, and especially in Kaposi's well known case of zona recurrens. So, also, general pruritus, (*Kaposi-Ueber Sensibilitats-Neurosen der Haut. Viertelj. f. Derm. u. Syph.*, 1876, *III Heft.*,) hyper-and-an-æsthesia, analgesia, (*Fournier on Syph.*,) and dermatalgia represent systemic revolts where the battle-field is, very truly, the skin; but the real enemy is the nervous system.

The multifarious conditions of increased, diminished, or perverted growth due to or influenced by vaso-motor, or other nerve agencies, are too numerous to be here considered. They are well summed up by Gamberini, (*Giorn. Ital. d. Mal. Ven. ed. Pelle.*, Aprile, 1877.) Among these may be found the nerve-nævi of T. Simon, alopecia areata, cell or pigment hypertrophies and atrophies, Hebra's erythema multiforme, Wilson's Nervous Excoriations, (*Lectures*, Lond., 1875, p. 192,) and others. Nor is it necessary to more than allude to the action of the mind upon the body through the nerves, as shown by cutis anserina, or pigment changes of the hair or skin due to mental emotion.

RUPTURE OF THE CORPUS SPONGIOSUM.

REPORTED BY

DR. THOMAS J. LOUGHLIN.

The following case is interesting, as illustrating a somewhat rare accident, which may occur during coition. Hugh G., aged twenty-nine, born in Ireland, and married, came under treatment for extensive extravasation of blood in the penis, scrotum, and perineum. His story was that, while having connection with his wife, his penis gave a "snap," which, according to his account, could be heard several yards away. Immediately afterwards his penis began to swell and give him intense pain. On examination, in consultation with Dr. Satterthwaite, the penis, scrotum, and perineum were found discolored by blood and greatly infiltrated with serum. It was thought probable at the time that there was rupture of the corpus spongiosum. Bandages and support to the penis and scrotum were ordered, together with external applications of lead and opium. When seen again, on the seventh day after the accident, there was discovered a bloody tumor at the junction of the penis and scrotum. At this point, it was surmised, the rupture had taken place. As the parts were greatly reduced in size, and were evidently returning to their ordinary condition, and the hematoma contained a considerable amount of serum, in addition to its blood-clot, the aspirator needle was introduced, and the excess of serum withdrawn. Three days later, however, suppuration set in within the sac. A free opening had to be made, liberating about two drachms of pus. On the fourteenth day the wound had

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healed and the parts were entirely restored. As bearing upon the cause of rupture, the patient said he had never suffered from any disease of the sexual parts, and there was no mechanical obstruction, or, indeed, any hindrance made to the "act." Since recovery coition has been successfully accomplished.

PERISCOPE.

COLLABORATORS.

Dermatology.—HENRY G. PIFFARD, M. D., Professor of Dermatology in the University of New York.
Diseases of the Nervous System.—EDWARD C. SEGUIN, M. D., Professor of Diseases of the Nervous System in the College of Physicians and Surgeons, New York.
Diseases of Women and Children.—FRANK P. FOSTER, M. D., Gynecologist to the Out-Patient Department, New York Hospital.
General Surgery.—EDWARD J. BERMINGHAM, M. D., Surgeon to the Good Samaritan Hospital for Diseases of the Rectum, and to the Out-Patient Department, Bellevue Hospital, New York.
Genito-Urinary Diseases and Syphilis.—ROBERT W. TAYLOR, M. D., Professor of Dermatology in the University of Vermont.
Ophthalmology and Otology.—S. B. ST. JOHN, M. D., Assistant Surgeon to the New York Eye and Ear Infirmary.
Orthopedic Surgery.—NEWTON M. SHAFFER, M. D., Surgeon to the New York Orthopedic Dispensary and Hospital.
Practical Medicine.—E. DARWIN HUDSON, JR., M. D., Professor of Practice of Medicine, Woman's Medical College, New York.

RECENT CONTRIBUTIONS TO THE PHYSIOLOGY OF THE BRAIN.

Messers. Frank and Pitres presented, during the month of December, 1877, two important reports on experimental researches into the functions of the brain. In the second, (*Progres Medical*, 19th January, 1878,) they state that by faradizing those parts of the white centre of the hemisphere which lie underneath the so-called motor centres, they were able to produce definite movements in the body on the opposite side. This tract of white matter, constituting the anterior portion of the internal capsule, contains distinct (physiologically) fasciculi, which are connected on the one hand with the motor districts of the cortex, and on the other with peripheral parts of the body across the median line. In the first communication, (*Progres Medical*, 5th January, 1878,) they report researches with respect to the speed of transmission of impulses produced by exciting various parts of the nervous centres, with the following general results: That the retardation of an impulse produced in the cortex cerebri in its passage to the middle of the cervical enlargement of the spinal cord, equals 9-200 seconds, and if 2 mm. of cortical gray matter be removed, the retardation falls to 6-200 seconds. They conclude that the cortex does not behave like a conductor, but like a centre.

These experiments are of great importance in the now much mooted question of localization of functions in the brain. They speak strongly in favor of the generally received view that the cerebrum

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does contain centres—the chief of which are now known; and they seem to utterly overthrow Schiff's theory of reflex action of the cortical centres. E. C. S.

TREATMENT OF FURUNCLES—NOTE ON A NEW PROPERTY OF ARNICA,

BY

DR. N. PLANAT.

(*Lyon Medical*, February 3, 1878.)

As the result of physiological experiments, Dr. Planat has been led to the use of arnica in all cases of superficial acute inflammation, as furuncles, anginas, erysipelas, etc. He states that arnica aborts all furuncular eruptions, except those accompanied by diabetes, with remarkable promptness.

For external use he employs:

RECIPE.—Extract of fresh arnica flowers, 10 parts; honey, 20 parts.

If this is too liquid he adds lycopodium. The mixture is applied to the inflamed part and covered with oil-silk.

Equally good results will be obtained in the same cases by the internal administration of tincture of arnica in does of twenty-five to thirty drops every two hours. M. Planat adds that the extinction of the furuncular eruption is so rapid that it seems impossible to deny a specific elective action. (*J. de Therap.*, 25th January, 1878.)

H. G. P.

GLYCERINE IN THE TREATMENT OF INTERNAL HEMORRHOIDS,

BY

DAVID YOUNG, M. D., Florence.

(*The Practitioner*, January, 1878.)

The author reports five cases in which marked and permanent benefit followed the internal administration of glycerine in from two to three drachm doses, in water, night and morning. In summing-up he says: The foregoing cases seem to show that we may be able to add glycerine to our list of palliatives for this troublesome malady. There are many patients who will not submit to surgical interference, and others—as, for example, consumptives in advanced stages of their disease—to whom one would scarcely recommend it, so that we are glad to welcome any means which would alleviate such a distressing condition. Not the least recommendation of this plan is, that it is both easy and pleasant, and probably also, especially in the case of phthisical patients, beneficial in some other respects. None of the patients to whom I have given it have experienced any difficulty in taking it, and, when the sweet taste is an objection, I usually order a little lemon juice to be added to each dose. E. J. B.

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ERGOT IN HEMORRHOIDS,

BY

EDWARD S. LANSING, M. D.

(*Philadelphia Medical Times*, October 13, 1877.)

Considering the pathological condition denominated hemorrhoids to consist in an enlarged condition of the veins, (an increased length and diameter, as a result of hæmostatic pressure at some time,) which continues after the inducing cause or causes are removed, simply on account of relaxed and feeble condition of their coats, and conceding the power of ergot upon that greatest aggregation of unstriped muscular fibres in the human system—the uterus—also its power upon the capillaries, where the presence of the unstriped fibre has with difficulty been determined, as in hæmaturia and chronic congestion of the spinal cord, it suggested itself that ergot ought to relieve, and, with so many favorable factors, one could reasonably expect it would cure many cases of hemorrhoids. Having an intractible case on hand, of twelve years' standing, I tested it. I used ergotin in suppositories, four grains each, night and morning at first; subsequently at night only. The first effects of the ergotin was to produce pain for half an hour or more; but, after the use of three or four, no unpleasant effect attended their use. The hæmorrhage ceased, the congested condition of the parts yielded, the hyperæsthesia was replaced by normal sensation, the hard, cordy condition of the veins passed away, and the slight tumefaction remaining suggested interstitial fibrinous exudation or cellular hyperplasia. Having treated five cases with the ergot, in four of which the result was more satisfactory than I anticipated, the fifth is still under active treatment. Having never seen the treatment suggested, and the result in my case being so happy, I offer it that others may test it, and possibly much relief accrue to a numerous class of great sufferers. E. J. B.

SEVERE INJURY OF THE SKULL AND LOSS OF BRAIN SUBSTANCE, WITH RECOVERY,

BY

M. G. PARSONS, M. D.

(*Journal South. Ill. Med. Association*, February, 1878.)

I was called, November 23d, 1877, to see William S——, aged eighteen, German descent, who had been helping to saw wood with a circular saw driven by a horse power. By pinching the saw in some way, the saw, together with the balance-wheel and the entire frame which held it, was thrown from the foundation on which it rested, while running at a high rate of speed, striking the patient upon the top of the head, ranging from back to front, in a line from the right ear to the left eye, making an incision of about five inches long through the scalp and integument covering the forehead, and through

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the outer table of the skull, of about four inches, and through the inner table two and one-half inches. The accident occurred at ten o'clock A. M., and I did not see him until dark that night. During the time, and until the wound was dressed, there must have escaped at least five or six drachms of brain substance.

Dr. Ormsby kindly assisted me in the operation, which was done by carefully removing the spiculæ of bone from the wound, several pieces of which were taken from the opening through which the brain escaped. In all, about fifteen pieces of bone were removed, some of which were picked out of the mangled portion of the brain, which, together with his excitement, caused considerable brain to escape during the operation. After removing all the loose bone, we drew the wound together with sutures, leaving the lower portion of the wound open for drainage. The operation was performed without an anæsthetic. Applied warm water dressings, gave brandy and morphine. Pulse ranging for the next twenty-four hours from forty to sixty, quite irregular most of the time. I saw the patient next day at four A. M. and twelve M. I found him quiet, pulse sixty; and more regular; had taken some nourishment. Bowels constipated, and it was with much difficulty that I succeeded in getting them opened, not until he had taken five or six ounces of sulphate magnesia. He suffered considerable pain, but was only unconscious during the first three days, and only at intervals. I visited him every day for four days; used carbolic acid dressing after the first night. Visited on the sixth day again, and found him convalescing rapidly. Dismissed him with orders that if any unfavorable symptoms should occur to inform me at once. All the treatment I gave him was bromide potassium, in fifteen-grain doses, every three or four hours, for the first three days. The patient came to town on the fifteenth day, a distance of ten miles, in a lumber wagon, and had not had an unfavorable symptom since the third day after the accident. I removed the two remaining stitches after he came to town. There is no depression and no tenderness in the region of the wound. The patient is now at work, and says he will go to the next war, feeling perfectly safe.

E. J. B.

OPERATION FOR THE CURE OF FISTULA IN ANO BY MEANS OF THE ELASTIC LIGATURE,

BY

J. L. SUESSEROTT, M. D.,

(*Philadelphia Medical Times*, February 16, 1878.)

Hannah H., aged about twenty years, had suffered some years with hemorrhoids, which resulted in two anal fistulas, one on either side of the outlet, and both including the greater portion of the sphincter. The one on the right side was situated farthest from the anal orifice, and extended about three and one-half inches alongside of the rectum.

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At the date above mentioned, after having secured a good state of anæthesia with chloroform, I introduced, by means of an eye-probe, into each track, a strong ligature, composed of the elastic cord so commonly used by ladies about their dresses, and also by milliners in their work. They were both drawn as tightly as could be conveniently done, and the patient was placed under the influence of a powerful anodyne. The one on the left side cut its way through in seven or eight days, the other one in about two weeks. Both fissures healed promptly, and the patient, who has since been the mother of one child, considers herself perfectly sound. No application was used to favor the healing of the wounds, and the suffering, which for the first few days was controlled by the anodyne, was hardly worth mentioning.

E. J. B.

IODOFORM AS A LOCAL APPLICATION,

BY

WYNDHAM COTTLE, M. A., M. B., OXON.

(*The British Medical Journal*, February 9, 1878.)

At a time when many new remedies are constantly being brought to the notice of the profession, and often lauded as of extraordinary virtue, but, after a longer and more extended trial, disappear from practice and are heard of no more, I should feel some disinclination to call attention to a not widely known drug, had not so high an authority as Mr. Berkeley Hill already done so. But, indeed, iodoform scarcely comes within this category. It has been in extensive use for some time by many surgeons, and, during the last two or three years, I have experimented with and prescribed it largely, and with the most encouraging results. First discovered about the year 1824, by Serullas, its properties have long been known to chemists. It is readily obtained by adding an alcoholic solution of potash to tincture of iodine, and crystallizes as a yellow lustrous coarse-grained powder of a peculiar pungent, penetrating odor. It stands in the same relation to its analogues, chloroform and bromoform, as hydriodic acid does to hydrochloric and hydrobromic. It may be regarded as chloroform, ($C H cl_3$,) in which the three atoms of chlorine are replaced by three of iodine, ($C H I_3$.) It also forms substitution compounds with chlorine and bromine. It is sparingly soluble in water and glycerine, less sparingly so in alcohol and warm oil, but ready soluble in ether, and to a still greater degree in chloroform.

Two years ago, I made solution of iodoform in alcohol and ether; but, as the liquid rapidly became of a dark iodine tint, I feared that some substitution-product or decomposition might take place in the liquid, and generally employed the solution in warm oil. Chloroform is, I believe, its most effective solvent. Iodoform can readily, by trituration, be made into an ointment with either lard or vaseline, and its odor, in some measure, disguised by the addition of essential oils,

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as the essential oil of almonds As a powder, it can be employed alone or diluted with Fuller's earth, magnesia, or tannin; the last-mentioned body having the peculiar property of, in some measure, removing its powerful and disagreeable odor. In the form of suppositories, iodoform has been employed as a local anodyne, but with no marked benefit, as I understand, though I have no experience of it in this respect. As a powder, it has been extensively applied to cancers and venereal sores; and I have to thank my friend Mr. George Perry for calling my attention to its use in these cases, when I was at once struck by the very remarkable results produced. Its action can, perhaps, be best shown by stating its effect in the several affections in which I have applied it.

VENEREAL SORES.—Iodoform seems to act equally well in these cases, whether they are ordinary venereal sores or genuine hard or soft chancres, and whether situated beneath the prepuce or on other parts. Its action seems to be that of a topical irritant in some measure, and it may set up too much local action, if applied to an inflamed sore or wound, as Mr. Berkeley Hill points out in his paper on the subject, in the British *Medical Journal* of January 26, 1878. It should not, therefore, be applied to a sore when acutely inflamed.

From records of cases, I find that twenty cases of venereal sores classed "Primary Syphilis," which occurred in practice in their chance sequence and without any effort at selection, were treated by me by the ordinary local methods, with or without internal remedies. These were, on an average, rather more than twice as long under treatment, before the sores were completely healed, as the same number of other cases, taken in a similar way, and under precisely similar conditions, in which the only remedial measure was the topical application of iodoform. These results are the most encouraging when I add that, in patients so treated, their is diminished risk of buboes and lessened constitutional depression from the more rapid progress of the cases. It seemed to me also that the sequence of secondary syphilis was less frequent. Iodoform acts particularly well in cases where there is a disposition to slough.

BUBOES, SYPHILITIC ULCERATION, ETC.—In practice, buboes that are most tedious and indolent are of frequent occurrence. They often have deep and extensive sinuses and fissures that show little or no inclination to heal, and sorely tax the patience, both of the surgeon and of the patient. I have found that these cases almost invariably rapidly granulate, contract, and cicatrize by the application of iodoform; and the same obtains in the late forms of syphilitic ulceration. A man, about twenty-eight years of age, with serpiginous ulceration of syphilitic origin, which, first breaking out in the groin, had extended over the lower part of the abdomen and upper part of the thigh, and was for over a year under treatment, with every likely remedy, including change to the seaside. In this case nothing seemed to check the morbid process, or to set up healthy action, till iodoform was called into requisition. Under its use the ulceration had almost healed,

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when the patient was lost sight of. I have often injected the deep sinuses that may result from buboes, etc., with a solution of iodoform, and have frequently found them mend under this treatment when other means have failed. As an injection in gonorrhœa, in the few cases in which it was tried, it seemed to set up so much inflammation that I abandoned its use.

CHRONIC ULCERS.—In ulcers about the lower extremities, and, indeed, elsewhere, I have formed a very high opinion of iodoform as a therapeutic agent. I have used it largely, both at the hospital and in private. Ulcers that have remained open for years, and on the treatment of which much care and skill have been expended, often close in a few weeks under its influence; but the same caution must be repeated as in the case of venereal sores. It will only irritate the actively inflamed wound. It is the indolent ulcer, from whatever cause it may arise, whether from varicose veins, malnutrition, syphilis or injury, that is especially benefited by iodoform. Repeatedly, under its use, I have seen a surface, glazed or œdematous, rapidly take on healthy action, granulate, and heal; and this where other measures have been tried for months, or even longer, without effect. Often, too, the pain that so frequently accompanies these ulcerative processes ceases after iodoform has been applied for a few hours.

AS A PARASITICIDE.—In many cases of ringworm of the scalp of long duration, and which have been before the subject of much and careful treatment, I have prescribed iodoform in the form of an ointment. In several of these a speedy improvement ensued, spores being no longer to be found, and the parts returning to a state of health; but I met, in some instances, with considerable difficulty in inducing the parents to apply the remedy, on account of its powerful odor. It set up no violent inflammation, and I hope it may prove an useful adjunct to the means at our disposal for combating that disease.

Chloasma quickly yields to this agent; but, again, its odor is an insuperable objection to its employment in the treatment of this disease. The results that I obtained from its application in several cases of sycosis were not encouraging, as it seemed to give rise to undue irritation. In the form of powder, I have used iodoform in several cases of lupus, with ulceration and rodent ulcer; but my observations on its conduct in these cases have not been, at present, sufficiently complete to warrant a definite opinion.

A word, in conclusion, as to its mode of application. If used as a powder, iodoform should be dusted on the ulcerated surface, and a piece of dry lint, soaked in a weak solution of carbolic acid, may be laid over it, and this process repeated night and morning. Undiluted, I have often found it apt to produce irritation and pain; and, therefore, generally prescribe it mixed with equal parts of either Fuller's earth or tannin. As a parasiticide, I have used it as an ointment with about twenty grains to an ounce of lard, and have directed it to be applied twice daily. Such an ointment, spread on lint, is a convenient mode of application to a wound or ulcer, and its employ-

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ment in this form prevents the risk of dropping this disagreeable smelling drug on the patient's clothes, etc. If an ointment of the strength named causes inflammation or pain, it may be diluted. I am also in the habit of ordering iodoform in combination with a salt of mercury, etc., with satisfactory results. So, also, it may most conveniently and easily be applied by painting the part with its solution in alcohol, chloroform, or ether, as Mr. Hill describes. E. J. B.

AMPUTATION OF ARM WITHOUT LIGATURES,

BY

R. H. MILNER, M. D.,

(*Philadelphia Medical Times*, October 27, 1877)

John Boyd, Jr., and Olmstead Greene, colored, were employed in blasting. They had bored a hole about two inches in diameter to the depth of twelve feet in the solid rock. This was charged on the evening of the third of March. On attempting to fire the charge on the morning of the fourth, it was found that the fuse had become saturated with water at some point, and would not carry the fire to the powder. Against the standing order of Mr. Malone, they proceeded to bore out the charge to make room for another. Unfortunately, just as they were about to succeed in this hazardous undertaking, the drill, an iron rod one and one-half inches in diameter, and twelve feet long, struck fire and ignited the charge. As both men had a tight grasp on the drill, which they were working with their hands, these members were literally torn to pieces. Boyd fared worst, losing both hands, the right being removed at the junction of the lower and middle thirds of the forearm. The left humerus was also fractured about the middle. The right arm was amputated first, and no trouble was found in finding and ligating the arteries; but on removing the left and slacking the tourniquet, it was found that no blood, with the exception of a little venous oozing, flowed. Nothing approaching the spurting of an artery could be seen, even after the tourniquet had been entirely removed. A most diligent search for the arteries was entirely futile. The patient was left with a competent attendant, while his fellow sufferer was attended to. At the end of two hours another and more thorough search for the arteries was made, with no better success. The stump was then dressed with interrupted suture, maltese cross, and bandage in the usual manner. The fracture was treated by placing the arm in a tin trough. The stump of this arm healed sooner than did that of the right, the healing of the latter being delayed by suppuration, depending on extensive powder-burns on the arm from the seat of amputation to the shoulder. There was at no time any hemorrhage from the left arm, nor was there any sloughing of the flaps. That the circulation was not interfered with by the fracture of the humerus is certain, as the pulsation of the brachial artery could be felt as far down as the elbow. E. J. B.

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THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY.

A SEMI-MONTHLY JOURNAL OF MEDICINE AND SURGERY,

EDITED BY

EDWARD J. BERMINGHAM, M.D., and FREDERICK A. LYONS, M.D.

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EDITORIAL.

SPECIAL NOTICE TO OUR SUBSCRIBERS.

In deference to the expressed wishes of a large number of our friends and subscribers, we have concluded to materially increase the size of the GAZETTE and to publish it as often as ONCE A WEEK. Whether our course will meet with general approval time alone will tell. We shall endeavor in the future, as in the past, to merit the approbation and support of each and every member of the profession, to whom we wish to express our thanks for the kind encouragement we have uniformly received. The journal will be conducted in the same spirit and with the same independence as has characterized it from the beginning, and our subscribers may rely upon the fact that the GAZETTE will be published solely in their interest. Editorially, the only change which will be made will be the addition of the name of Dr. H. H. Kane, as *Associate Editor*. Particular attention will be given to reporting the best clinical lectures delivered in New York and Philadelphia, to the "Periscope" and "Hospital Records." We shall also from time to time give translations of the admirable clinical lectures delivered at the Parisian hospitals, and shall not ignore our German cousins, to whom medical science owes so much. In short,

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all the departments of a well-conducted journal will be represented, and we shall aim at the highest standard of medical literature.

Hereafter the GAZETTE will appear regularly every Thursday. Each number will contain twenty closely-printed pages of reading matter, making 1040 pages annually, instead of 576 as at present. Notwithstanding this very great increase in the amount of matter furnished, the subscription will be placed at the remarkably low price of $2.00 per annum, including postage; thus placing the journal within the reach of every practitioner. The first weekly number will be issued on April 4th, and there will be no alteration in the form or paging of the GAZETTE.

SURGEON-GENERAL WILLIAM A. HAMMOND.

The committee on military affairs of the U. S. Senate to whom was referred the bill for the relief of William A. Hammond, late Surgeon-General of the Army, which authorizes the President to review the proceedings of the court-martial by which Dr. H. was tried in 1864, and to annul and set aside the proceedings of said court-martial, should he deem it proper so to do, and also to place Dr. H.'s name on the retired list of the army; has reported favorably thereon.

We are certain that every one acquainted with the facts of this case will be pleased to hear that such a distinguished member of the profession and accomplished gentleman, is about to have a wrong redressed after so many years. It must be gratifying to Dr. H. to know that throughout the 14 years which have elapsed since his trial, he has always had the confidence of the profession, and as far as we can learn, not a single member conversant with the facts at the time, believes that Dr. H. was guilty of anything more than an error of judgment, and that the real cause of his degradation was the ill-will of his powerful superior in the war department, Secretary Stanton. It is quite evident that the Senate committee views the matter in this light, as it is disposed to give the doctor permission for a review of his case and to repair the damage inflicted in the only way possible,—an honorable restoration to the army. In summing up the report to the Senate, the committee says:

"Let Dr. Hammond, in event he shall satisfy the President of his right thereto, be restored to his family, his friends and his profession, freed from every taint or blemish which has hitherto been inflicted upon him under fortuitous circumstances. His brethern of the medical profession honor his name and fame, and his countrymen look upon him with pride as foremost in the ranks of American Scientists, humanitarians and gentlemen. Your committee believe this to be a case wherein the Constitutional prerogative of Congress to redress grievances may be safely, justly and fairly exercised, especially since the President is invested, by the provisions of the bill, with wise discretion. If he find against the merits and equities of the case, then the relief sought must be denied. If he find otherwise, and

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hence favorably, Dr. Hammond will then receive that reparation to which he is entitled, and which avoids, by the terms of the bill, all reflection and humiliation upon any other party concerned."

IMPROPER EXHIBITIONS.

Some time since we had the curiosity to stray into a place of amusement known as the "New American Museum," and were surprised to see a couple of poor, harmless idiots exhibited under the name of "Wild Australian Bushmen." We wondered at the time that the humanitarian Mr. Bergh had not taken cognizance of an act so revolting to refined and cultivated people, and should have directed his attention to the matter at the time, had not other affairs of importance supervened to preoccupy us. We subsequently learned that the poor unfortunates had been removed to other quarters.

Lately, however, we heard that a "double-headed child" was the great attraction at this place of amusement, and in order to verify the report we took occasion to visit the resort. We found a poor little unfortunate, at that time nine weeks old, who was deformed by what seemed to us to be a cephalobifida, the tumor being as large as its head proper. The parents, who were present, and had charge of their offspring, would not allow an examination to be made, so that we cannot speak positively as to the nature of the excresence. The father seemed proud of his distinction, and told us very confidingly that the child had a double passage, and that the excrement from each was of different colors.

We do not wish in this place to discuss the case as one of scientific interest, but to look at it altogether in its moral aspect.

It seems to us to be revolting in the extreme for a poor little harmless sufferer from such a formidable disease, to be exposed thus to the public gaze. If the parents themselves have so little self-respect as to sacrifice the commonest feelings of humanity by allowing their malformed offspring to be made the object of the morbid curiosity of vulgar spectators for the sake a little money, they should be compelled by law to desist from offending the moral sense of the community by putting up such a pitiable object for exhibition. The idea of exposing to public view the sufferings and monstrosities of human nature, for no useful purpose, is so disgraceful to all right-thinking people that it is a marvel that such a thing is tolerated for an instant. The managers of a place of *amusement* who make money in such a disreputable manner, are too barbarous to be tolerated in a civilized community, and the place where such an exhibition is made should be closed.

We have a Society for the Prevention of Cruelty to Children, and we think no worthier case for their interference could be found. Not only is it an enormity against the child, but the moral effect on the people is debasing to the utmost degree. Such an exhibition is unpardonable, and cannot be excused in any way. It is time that some influence should be brought to bear in the right direction to have such outrages stopped.

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NEW YORK COLLEGE OF VETERINARY SURGEONS.

Among the college commencements celebrated recently was that of the New York College of Veterinary Surgeons, which, according to the newspaper accounts, went off with a great deal of éclat, the trustees and faculty having been honored on the part of the laity by the venerable philanthropist, Mr. Peter Cooper; and on behalf of the medical profession by no less a personage than Prof. Wm. A. Hammond, who delivered the address of the evening, upon "Equine Psychology."

Any effort to elevate veterinary medicine to the position of a science should meet with the encouragement and support of every cultivated and high-minded person, and more especially should the members of the medical profession countenance and sustain an institution, the object of which is to educate men to intelligently and scientifically treat our domestic animals. To such a course we should be the last to take an exception, but when we see an institution engaged in what the profession understands as "irregular practices" receiving the support of those to whom we look for an example of professional honor and probity, we cannot refrain from calling the attention of the medical public to the facts.

We have before us a large circular entitled "The People's Declaration of Facts!!!" which is a collection of testimonials regarding the efficiency of a "Superlative Cure" "prepared only by Geo. W. Busteed," who is the Medical Director of the New York College of Veterinary Surgeons. This "Superlative Cure" is one of the many *cure-alls* with which the drug market is flooded, and on the circular we find the following names endorsing its many virtues: E. G. Rawson, M.D., President of the New York College of Veterinary Surgeons; R. Kelly, one of the trustees, and D. C. Comstock, M.D., and L. G. Fairchild, Ph.D., members of the faculty of the same institution. We have seen a bottle of this "Superlative Cure," the label of which is embellished by a portrait of the proprietor.

This one fact which alone should be sufficient to condemn the institution as far as the medical profession is concerned, but it is not the only one in existence. Amongst the faculty we find the name of "J. A. Going, M.R.C.V.S., Prof. of Surgery and Surgical Pathology." For the enlightenment of the profession we would place alongside of this the following advertisement, from a leading sporting paper:

WORMS! WORMS! WORMS!
(Here follows a testimonial.—Ed.)
GOING'S WORM DESTROYER,
Prepared by Prof. J. A. GOING, M.R.C.V.S.E.,
Veterinary Editor "*Spirit of the Times*,"
&c., &c.

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Another advertisement reads:

What is the Matter with My Horse?
WORMS! WORMS! WORMS!
What will Cure Him?
GOING'S WORM DESTROYER!
&c., &c.

We would say that this is only a small fraction of the advertising done by Mr. Going, who is the representative man of the faculty of the New York College of Veterinary Surgeons. He is the proprietor of "Copeman's Tonic Powder for Horses," the recipe for which, his advertisement informs us, he purchased from the widow of the late Prof. Copeman. As "Veterinary Editor" of the *Spirit of the Times* he is engaged in corresponding openly with horsemen in all parts of the country. Periodically he makes a circuit, his appearance in each place being heralded beforehand. We have seen a circular from Mr. G. setting forth his qualifications, and addressed to a gentleman in this city, soliciting his patronage.

We think that, in the face of these facts, no professional man—no physician bound by the ethics of the profession—has the right to recognize such an institution, and we are certain that every medical man connected with the college will receive the censure of his professional brethren. Indeed, when the County Society thought proper to insist upon the withdrawal of professional names from the advertisements of the Apollinaris and Hunjadi Janos waters, we are sure that as soon as its attention is called to this institution that a similar course will be taken with those connected either directly or indirectly with it and coming under the jurisdiction of the Society.

But to return to Dr. Hammond. He has certainly brought no honor to the profession by the course he pursued of officiating at the commencement of this institution; and if we are informed correctly, the character of the college was fully explained to him one week before the commencement exercises, but he declined to withdraw from his engagement. We cannot congratulate the doctor upon the honor of addressing this graduating class—three in number; two of whom, we understand, had been rejected at the examination for their degree, when the college was under praiseworthy management. The third graduate was the brother of Prof. J. A. Going.

The following are the medical men connected directly with the New York College of Veterinary Surgeons:

Edmund G. Rawson, M.D., *President of the College and Emeritus Professor of Theory and Practice.*

D. C. Comstock, M.D., *Sec. of Faculty, and Prof. of Anatomy, General and Comparative.*

Thos. A. Hawkins, M.D., *Prof. of Physiology and Chemistry.*

Erskine S. Bates, M.D., *Prof. of Materia Medica and Therapeutics.*

Edward C. Mann, M.D., *Prof. of Histology and Pathology.*

Thos. H. Skinner, M.D., *Prof. of Obstetrics.*

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LECTURES.

LECTURES ON PARALYSIS AND CONVULSIONS AS EFFECTS OF ORGANIC DISEASE OF THE BRAIN.

Delivered at Bellevue Hospital Medical College, New York,
BY
C. E. BROWN-SEQUARD, M.D., ETC.

LECTURE VII.

GENTLEMEN—In the preceding lectures I have tried to show that though the symptoms are exceedingly variable in brain disease, we can generally come to the diagnosis of the seat of the lesion. To-day I shall continue on the same subject. What remains to be examined is what relates to the convolutions of the brain. Certainly they are parts of the cerebral structure that produce exceedingly variable symptoms. We may have a great deal of difficulty in coming to a conclusion as to the seat of the lesion, but still there are some points that may lead us to a correct diagnosis.

Before coming to the symptoms produced by disease, there is one point, which I have already mentioned many times, but which I must now again revert to. This point is, as to whether the convolutions contain the psycho-motor centers.

Within the last five or six years there has been a great effort in Germany, England, France, and in this country to determine and prove this point. There has been a strong effort to show that certain parts of the convolutions of the brain are places in which the will power acts to produce voluntary movements. The parts in front of the fissure of Rolando, and behind, and near the Sylvian fissure are the parts where the will power acts to produce voluntary motion. The facts on which these views are grounded are extremely interesting, and one discovery by Fritsch and Hitzig possesses a great degree of interest, and deserves more than ordinary attention.

It was believed that the brain substance, at least in the central portion, was not excitable by any of the means of irritation that we possess, galvanism, mechanical irritation, such as tearing up or pricking the nerve tissue, chemical irritants, such as the mineral acids, etc., and thermic irritants, such as the hot iron. As you well know, when we apply such irritation on a nerve or the spinal cord, or on the base of the brain, we may produce reflex or direct movements if the part irritated is a motor part. No doubt if we found that any of these agents, by irritation of a central part of the brain, would always produce the same kind of movement, it would be established that that part of the brain is excito-motor or has a direct power of producing that certain movement. This, however, is not so. The only agent that will produce such an effect is galvanism. Therefore there is a radical difference between these and other parts of the brain, and as you well know, galvanism can have a diffuse effect whenever it is applied. Its effects

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may certainly be propagated from the point to which it is applied to other parts at a distance. This is a way of explaining the effects observed when these portions of the brain are excited by galvanic irritation, if you refuse to admit that they are centers presiding over voluntary motions.

Again, experiments have been made to show that galvanism applied to the convolutions is propagated and that the movements which take place under this irritation only occur sometimes and not always. There is no doubt—from the labors of certain friends and pupils of mine, led in a measure by myself, although I was mistaken—there is no doubt, that local galvanization of the convolutions may be followed by certain muscular movements, but this is no proof whatever that the part thus acted upon is a psycho-motor center.

To use an old illustration, if we tickle the sole of the foot, we may produce certain muscular movements of the face that we call laughter, but we certainly do not look upon the sole of the foot as the psycho-motor center for these movements. The same reasoning applies with full force when we consider the movements produced by irritating the convolutions of the brain. There is no reason to conclude that the irritation acts directly on a motor organ. A motor center may have been excited, but it has been through a propagated influence, and a reflex action is the consequence. It is, I repeat, the same thing as occurs whern we tickle the sole of the foot.

This view is certainly more in harmony with the facts than the one generally admitted. If it were the case that a motor organ is excited by the irritation, all irritants as well as galvanism should produce the same effect. Moreover, if these parts were taken away, we should get paralysis of those muscles that act in causing the contraction, and this paralysis would be persistent. In animals, when these parts are taken away, an appearance of paralysis will come on, but when we investigate this, we find that the apparent paralysis is similar to the general paralysis of the insane, in which the convolutions are inflamed and there is irritation of other parts of the brain tissue. It is simply a disorder in the action of the will power, and not paralysis that is present in these cases. When these parts are taken away and such results are seen to follow, it would show, if it led to any conclusion, not that they preside over the voluntary motor actions, but that they serve to maintain the equilibrium.

The second conclusion, however, that the convolutions maintain the equilibrium of the body is not true. If, instead of taking away the pretended psycho-motor center alone, we remove a great deal more of the tissue, we ought to have, certainly, no power of producing these movements left. There may be no paralsysis. There ought to be a greater paralysis, but in many cases there is not only no paralysis at all, but not even the appearance of it. If you only take a part of the organ away you will have more disorder of movements than when you remove the whole of it. The effects that are seen then can only be the effects of irritation.

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Longet found in one case, that after producing apparent paralysis on one side of the body, by taking away the so-called psycho-motor centers, when he took away the corresponding centers on the other side of the brain, the paralysis produced by the first operation disappeared. He should unquestionably, if the theories were true, have found a second paralysis on the opposite side, and no change whatever in the side that was first paralyzed. This is decisive in showing that an irritation is produced in another part of the nervous system by the first injury. By the second operation you produce cessation of the apparent results of the first.

Professor Bayer, of Paris, experimented on a chameleon by removing the brain on one side, and the result was paralysis of the other side of the body. He then took away the other half of the brain, and instead of producing the same condition on the sound side of the body, the paralysis that appeared from the first removal disappeared. In this case one half of the brain had been removed, and the paralysis produced appeared to be due to the fact that the voluntary motor centers had been taken away, and the second operation, removal of the remaining half of the brain, instead of being followed by a second paralysis of the other half of the body, was followed by the cure of the the animal of the first paralysis, that produced by the removal of the first half of the brain. This is a mode of treatment, however, that I should not advise in the human subject.

From the facts that I have related, it follows that there is no reason to conclude that paralysis depends on the loss of an organ employed by the will power. The reality is, that when paralysis appears, it is due to an irritation which starts from the place in which the disease is situated, and from that point spreads its influence to many others in the cerebro-spinal system, and causes, by an inhibitory influence, a cessation of the activity of those cells to whieh it has spread, and thereby produces paralysis. The results of all the experiments with galvanism tend likewise to show that paralysis may be produced by irritation in this way.

Bouchfontain found that the application of galvanic stimulus to the dura mater, or even simple gentle friction with the nail, according to where it was applied, could produce a movement of either the arm or leg. From this fact are we to place the center of will power for movement of the leg or arm in the dura mater?

Even those persons who believe in the existence of the psycho-motor centers admit that paralysis, apparently due to their removal, disappears after a time. It is, therefore, plain that in these cases we have to deal with something else besides the ablation of an organ.

A great effort has been made by Prof. Charcot to show that certain conclusions, as regards the motor centers, must necessarily be drawn from clinical facts. He has shown that certain parts of the convolutions of the brain have more power in producing paralysis than others. There is no doubt that certain parts around the fissure of Rolando, when they are subject to disease, will give rise to paralysis more

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frequently than when the disease is in other parts of the convolutions; but if you examine the facts, you will find but very few which are in harmony with the admitted theory.

According to these observers the anterior convolutions contain centers that move the tongue and lips, and those in front of and behind the fissure of Rolando serve chiefly for the movements of the arm and leg. These parts and some others, that it is not necessary to mention more particularly, along the central fissure of the brain, are the so-called psycho-motor centers.

We find many cases in which disease has destroyed these parts without the production of any marked paralysis. These facts are certainly quite sufficient to show that the conclusions are wrong.

If you examine the facts seemingly in harmony with the theory, you will find in many cases where the disease has occupied only small parts, that there still may be complete hemiplegia. In other cases we find that the face is paralyzed together with the arm when the lesion is situated in that part of the brain considered to be the motor center for the leg. Indeed, the discrepancies between the cases and the conclusions of physiologists from their experiments are decisive against the theory.

Is it possible, however, to diagnosticate a disease existing in the convolusions of the brain, even when the disease is elsewhere than in the psychomotor centers so-called? Sometimes it is so. Disease somewhere else may produce paralysis of the same kind, but we must endeavor to look as carefully as possible for the seat of the disease, as the means of treatment vary according to the location of the lesion.

If the disease is in the convolutions together with paralysis, there is a likelihood that convulsions will occur. Convulsions occur more frequently when the disease is in the convolutions than when it is in any other part of the brain. So much so, that Dr. Wilkes, of Guy's Hospital, thought that epilepsy was due to disease in the cerebral convolutions, and I made an equal mistake when I considered that it depended always on disease of the membranes outside or inside of the ventricles. There were a great many facts in favor of my view, but also a great many against it. However, in many cases where the disease is situated in the convolutions, it is likely that we will have convulsions with the paralysis. So then, when we have convulsions present in such cases, we may suspect that the disease is in the convolutions, and examine carefully for further evidence.

With disease here, it is frequent to find disorder in movements, if movement remains. Nearly always there is not simply loss of voluntary action but also disorder of movement. Then, besides, the paralysis is usually much less in extent than in disease in other parts of the brain, and the paralysis is chiefly marked in the arm.

Again, the convolutions of the brain are employed in the exercise of the noblest faculties of the mind, and, therefore, there will be some disorder in the higher faculties when they are the seat of the disease. If the lesion is on the left side of the brain, whether or not it be in

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the third convolution, there will be great difficulty for the patient to find the proper words by which to express himself. Amnesia is frequent, and very frequently there will be complete loss of power of expressing ideas by speech. So that there are a number of symptoms that may lead us to localize the lesion with considerable accuracy.

Other features are interesting. There is frequently contracture of one limb, oftenest of the arm. If the disease has existed for any length of time, as from a tumor, this is more likely to occur. It is very frequent to find this rigidity in the limbs, especially in the arm.

Prof. Charcot tried to explain this, on the ground of secondary degeneration. That portion of the convolutions in front of the fissure of Rolando is the part, disease in which chiefly produces the rigidity. Charcot showed that the secondary degeneration extends from this situation to the pons Varolii, the medulla oblongata and the spinal cord.

The convolutions of the brain have also peculiar features that may help up us in making a diagnosis. My friend and former assistant, Dr. J. Hughlings Jackson, was the first to clearly show the features that usually belong to these cases. If epilepsy or convulsions appear as the result of the disease in the convolutions, the arm especially, but sometimes the leg, will be seized by a cramp before the attack. Sometimes with these attacks there are peculiar sensations, as formication, or burning or pricking sensations, and for a while the symptoms are localized in one limb only.

These features are not absolutely peculiar to disease in these parts, but certainly belong far more frequently to lesions here than to lesions in other parts of the brain.

I cannot review all the symptoms which will lead us to the diagnosis of the lesions that produce paralysis, but I will now repeat in as few words as possible the reasons that lead us to localize the disease.

If you find paralysis in the limbs, with paralysis of the face on the opposite side, you may look to the pons Varolii as probably being the seat of the lesion.

If you find paralysis with hemiopia, there is likelihood that the disease is in the tubercula quadrigemina.

If you find paralysis coexisting with complete loss of action of the third pair of nerves, and paralysis of the limbs on the opposite side of the body, then the disease is probably in one of the crura cerebri. These are the most important features.

I now pass to another point,—the study of convulsions in connection with brain disease. Convulsions, as you know, may appear without epilepsy. They are certainly distinct from epilepsy proper. What essentially characterizes epilepsy is loss of consciousness. There is, indeed, no need for convulsions to be present in attacks of epilepsy. In the *petit mal* of the French or epilepsy *mitior* of the English there is no necessity of convulsions or rigidity of any muscles

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in the body. There may be a simple loss of consciousness from many causes, but for epilepsy there must be a few such attacks, as loss of consciousness itself cannot constitute epilepsy. When loss of consciousness occurs from arrest of the heart we have syncope, but when the heart continues to beat, and there have been a number of attacks of loss of consciousness, then we have epilepsy. But I have seen very few cases in my experience in which there were not convulsive movements of some muscles, especially of some of the muscles of the face or neck. There may be such cases, but epilepsy is usually characterized by two series of manifestations, loss of consciousness, and two kinds of convulsions. The first is rigidity or tonic spasms, almost always coming at the commencement, and second, the other series of movements or clonic convulsions. These usually exist in succession, the tonic convulsions preceding the clonic. These varieties occurring in succession, in repeated attacks, with loss of consciousness, constitute complete epilepsy.

In brain disease very frequently you have not to deal with epilepsy proper. Convulsions very frequently occur without loss of consciousness in such cases.

Other symptoms characterize convulsions dependent on brain disease, as compared with those occurring in idiopathic epilepsy. In the latter case the convulsions are almost always alike on both sides of the body. In convulsions dependent on brain disease they are very rarely alike on both sides. The head is drawn to one side, and the eyes are moved to one side, and there is a difference in the limbs on the two sides.

Another feature is, that one side of the body alone is frequently attacked with convulsions in disease of the brain, but in epilepsy this is never the case. Convulsions, then, occurring on one side of the body, lead to the suspicion that disease of the brain is the cause, especially when the convulsions are limited to one limb, as the arm or the leg.

In cases of convulsions due to brain disease, what was called by Galen and other physicians of his time an *aura*, will occur. Another feature of epilepsy due to brain disease is its curability. I may surprise many practitioners in this room when I say that epilepsy proper, or simple convulsions due to brain disease, generally can be cured, while on the other hand, hardly one case in a hundred of idiopathic epilepsy can be cured. So you see that there is a radical difference. It seems strange that in such cases that seem to be the more aggravated conditions our means of cure are more certain.

When epilepsy depends on disease in special parts of the brain, as in the base, our means of treatment may cure the case rapidly; that is, we can prevent the manifestations of the disease in its commencement, and by so doing we can cure it in time. The patient may have subsequent attacks within two years, but each attack may be averted, so that he is completely cured only after some time; though, as I said, the manifestations are prevented.

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There is no doubt that epilepsy from brain disease depends simply on an irritation of certain parts of the brain, on which our means of treatment exert a powerful and controlling influence. It may be that before a very long time has elapsed we shall have the same great power over paralysis as we now exert over convulsions, as, according to the theory I have set forth, it is only a manifestation of irritation, in the same way as convulsions.

An irritation starts from a certain point and produces an inhibitory effect, a cessation of activity on cells at a distance, and paralysis results. If the irritation goes to cells that are able to produce reflex action, instead of to simple motor cells, another irritation is produced and convulsions occur. It is essentially the same cause in both cases. An irritation starts from a certain point, is propagated to distant parts, and produces paralysis or convulsions, according to the properties of the part on which it acts. If we can cure convulsions dependent on brain disease, we may find means to cure paralysis as well, for they are both dependent on the same cause. What has already been discovered as regards anæsthesia is most important as regards our being able to cure paralysis.

I now pass to the study of certain features that present themselves with convulsions, due to disease in the brain. These are the *aura* or warning symptoms that precede the attack and the loss of consciousness.

First, as regards the *aura*. I wish every one would study with great care every case of epilepsy to see whether or not this exists. It is true that it is very difficult for a busy practitioner to examine every part of the entire surface of a patient's body, but not to do it is a lack of employment of our knowledge, and we do not do our whole duty to our patient if we neglect it. I know that I myself have been guilty of such neglect. I will state the facts that have led me to these remarks. I have found that irritation of certain parts of the body in epileptics will often, and in some cases always, produce an attack of the disease. I have not dared in many cases to produce an attack by such means, but in a few I have. I never wish intentionally to produce an attack, but it is important in some cases to ascertain whether we have to deal with epilepsy due to organic disease of the brain, or to some other cause. In this way we bring the attack to be like those that are preceded by an *aura* appreciable to the patient. If there be an *aura*, and the place where it starts from is determined, then the application of a variety of means of counter-irritation has a great power of curing the attack. So, if you produce an attack of convulsions in this way, the patient is well repaid, as counter-irritation applied to the part may produce a cure of his disease. This spot may be situated in any part of the body so that an irritation applied to the back of the head, or neck, under the ear, or under the jaw, at the level of the origin of the vaso-motor nerves, the first or second dorsal nerves, the knees or other parts of the limbs, in some cases the breast and so on, may be the means of curing the

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epileptic seizures. Abercrombrie and Bright had cases like these. Reeves Clark had a most important case in which a touch on the breast produced an attack. In these cases counter-irritation applied to these points may effect a cure.

The *aura* may vary greatly. It may consist in a peculiar movement or in a sensation; the movement may occur anywhere in the body. I had a case in London in which there was such a violent contraction of the bladder that the urine was forced out with great rapidity. This occurred two or three hours before the attack. Any muscle in the body may contract in this way. The organs of the abdomen or chest may be affected in like manner. Any muscle of the limbs or trunk may contract in the same way as did the muscles of my patient's bladder. As you well know, there are muscular fibres surrounding the blood vessels. On this account you will get a pallor of the part in which the contraction occurs. It may be in the face or elsewhere. There is likewise a diminution of the temperature of the part.

There is, therefore, a kind of *aura* which consists in muscular contractions in various parts of the body. The bronchi, the diaphragm, the intestines, in fact any part may be subject to this contraction. The important point, for the sake of applying means of treatment, is to determine whether such a place exists, and if it is a constant place, and if the *aura* frequently occurs there previous to an attack. If such a place can be found, you have a great chance of doing a good deal for the patient by applying means of counter-irritation.

Another kind of aura is one of sensation. It is variable, but it generally consists of an indefinable sensation. The patient cannot tell what it is like. Its peculiarity is that it is like itself and nothing else; in fact, it cannot be accurately described. It belongs only to that peculiar state. Some physicians think that the term aura should be limited to this peculiar sensation, but the term should apply to everything that takes place before the beginning of the actual attack. In those cases in which the aura appears long before the attack we have great chances of staving it off.

I pass now to the consideration of loss of consciousness. In 1857, in this country, in a work on epilepsy, I tried to show what is now admitted by physiologists and physicians, that the loss of consciousness is the result of the contraction of the blood vessels in the cerebral lobes. I am sorry indeed that my ideas were followed, for I now believe that it is only partly true, if true at all. I am quite certain that the blood vessels contract, for I have seen it many times, and the fact is beyond dispute, but just as in the case of sleep, as shown by Dr. Hammond, the contraction is not essential. To say a few words about sleep, the contraction of the blood vessels is so little essential to that phenomenon, that in animals in whom both sympathetics have been divided, and where there can be no contraction, but on the contrary a state of congestion exists, sleep takes place just as well as if the blood vessels of the brain were contracted.

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It is clear, therefore, that contraction of the blood vessels of the brain is only something that takes place during sleep, and is not the cause of sleep. So that a remedy that produces contraction, given in order to produce sleep, is wrong. The contraction of the blood vessels is not essential; it may be accidental.

I will consider in the next lecture the cause of loss of consciousness in epileptic attacks.

CLINICAL LECTURE.

Delivered at the Hospital of the University of Pennsylvania.

BY

WM. GOODELL, A.M., M.D.,

Professor of Clinical Gynæcology.

I. CONICAL CERVIX. II. DYSMENORRHŒA. III. DIAGNOSIS OF OVARIAN CYSTS.

CONICAL CERVIX.

This woman has been married a year and a half and has not yet conceived. There is evidently a fault somewhere. The most frequent causes of sterility are: (1) extreme anteflexion and (2) what is known as a conical cervix. Let us see what is the matter here. The patient tells me that previous to her marriage she was perfectly well, but that since that time she has had a good deal of uterine trouble, as shown by painful micturition, difficulty and pain in her sexual relations and great dysmenorrhœa. Upon examination, I find the cervix to be very small, not any larger, in fact, than the tip of my little finger. I also find that it projects fully three quarters of an inch into the vagina. The external os of the cervix is also unusually small; a pin-hole os. The womb is slightly prolapsed. It is very easy to see what has been the cause of the pain experienced during copulation, for (1) the distance from the fourchette to the cervix uteri is only an inch and a half; and (2) the vaginal walls are tense and inelastic. The patient, furthermore, tells me that there has been copious leucorrhœa since her marriage.

I have inserted the speculum. You see how much difficulty I have in expanding the blades. Indeed, were I to set to work roughly, I might tear the vagina. Let me give you a piece of information while I am slowly opening these blades. All the anterior portions of the sexual organs are exceedingly sensitive, while inside of the vagina the parts are so insensitive, that even the application of pure nitric acid to the cervix or womb, gives but little pain. The os of the cervix is, as I told you, very small, but still I can get the sound in without much difficulty. The womb is of the normal length, but is slightly anteflexed. How do I account for the dysmenorrhœa? There is a good deal of endometritis here; the lining membrane of the womb is so thickened that it has, to a great extent, occluded the abnormally small cervical canal at the time of the menses.

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It is necessary to the mental and physical happiness of a woman that she should have children. Unless a woman conceive within a year or so after marriage she is very likely to have obscure neuralgic pains and severe uterine disorders. This being the case, we must try and place our patient in a position in which conception will be possible. How shall I bring about this desired result? There are two methods: (1) by gentle dilatation of the cervical canal, or (2) by weekly applications to the lining membrane of the womb and cervix. I think I will first try gentle dilatation. The os is entirely too small. I am not going to give ether, because its use would destroy, to a large extent, the good effects of the dilatation. The operation is a painful one, and so I must work very gently. While I have been talking to you I have expanded the blades fully one-third of an inch. The canal is now large enough for me to pass in a piece of cotton. As I intend to employ both of the methods of treatment above-mentioned in this case, I will ask the woman to come here every week regularly and have an application made to the womb of saturated tincture of iodine. There has been but very slight bleeding, as you see.

You will come across such cases as these very frequently in your practice. In some instances you may have to put your patients under ether and dilate the os forcibly. Why did this trouble grow worse after marriage? or, rather, first let us ask why was the woman sterile? In intercourse the male organ pushed the cervix to one side, and so the semen did not find its way into the opening. Even if this had not occurred, the angulation would completely occlude the canal so far as the passage of semen was concerned. Why does sterility produce uterine disease, you will now ask? Pregnancy and lactation call a temporary halt in the progress of constant sexual excitement, but when conception does not take place, the sexual excitement goes on and the congestion becomes greater and greater. This congestion, when the time of the menses approaches, increases the flow, and also increases the secretions of the womb. The blood and secretions are retained, the womb swells, endometritis, perhaps hyperplasia, takes place, and the cerivix and womb become so sensitive that the woman cannot tolerate the marital approaches, or at least cannot complete the act as soon as the husband. Thus the excitement on her part is kept up without the succeeding relaxation. You will very often have newly-married husbands come to you and tell you that they constantly find themselves completing the act of copulation before their wives. Very many women know so little of such matters that it takes them a long while to be educated up to the point of reciprocity with the male. This state of affairs may be due to perfect purity, or an entire apathy in such matters. Where it is due to apathy there is not so much danger, for in that case there is little or no congestion of the parts. Otherwise, *i. e.*, where the husband completes the act first, it is very hard to know what treatment to pursue. I think the best plan is to order the husband to sleep in a separate bed, so as to remove the temptation to too frequent approaches. Abroad, married

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persons always sleep in separate beds. Very few men will be reasonable if allowed to sleep with their wives under such circumstances. I am inclined to think that very many cases of severe uterine disease date from the honeymoon, the time when young couples go away from home for this very purpose. But too often both parties are permanently injured by the excesses indulged in during these first few weeks spent away from home, and entirely given up to pleasure seeking of all kinds in general, and particularly of one.

DYSMENORRHŒA.

A celebrated Western gynæcologist spoke to me at Boston last summer of a new method which he had employed for treating dysmenorrhea. He said he took pieces of the bark of slippery elm, and whittled them to the size of matches, then tied a string to each and packed the cervical canal with them. It struck me at the time as an excellent plan, and I determined to employ it in the first case of dysmenorrhœa in hospital practice that fell to me after I returned. That case happened to be the one I now bring before you. I put the slips in three times. After removing them the third time the woman had a severe attack of peritonitis. I will not despair of the remedy because it failed me once, but I will not try it again in this case.

You must always be very tender in examining the womb and cervix of a patient who has lately had pelvic peritonitis. Never make any irritative applications to the womb in such a case. I am going to insert my finger here and move the womb about very gently to see if any pain or plastic adhesions remain. This woman, since the attack of peritonitis, has experienced a great deal of pain in passing her water. However, the angulation of the canal would explain this. There has also been a good deal of leucorrhœa. I intend to pass a sound very gently. It stops at the internal os. Now, it would be very bad surgery in such a case as this to go on and dilate after giving ether. There is not much pain at the os externum, and it is quite roomy ; so the slippery elm did some good after all.

What will be my treatment? I will tell this woman when she goes home to put one drachm of chlorate of potassium in a gallon of water and to syringe her vagina out well with this solution. She had better use a fountain reservoir or something of the sort for this purpose. The water must be so warm that she can just put her elbow in it —from 110° to 120°. The reservoir ought to be put on the mantlepiece, and the water finds its way into the vagina through a length of rubber tubing. We are indebted to Dr. Emmet of New York for this suggestion. I would like the patient to try this daily for a month's time, and then to retnrn to us and report progress. Among other things, walnut leaf tea is a very excellent vaginal application in these cases.

When the patient returns at the end of the month, how shall I treat her? I shall make an application of carbolic acid to the fundus of the uterus. I shall then introduce an Elliot's repositor, and turn the

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handle of the instrument. The womb will thus be carried in the same plane into a position of retroflexion. When you use an Elliot's repositor you must work very slowly, or you will cause the patient a great deal of needless pain. Do not introduce this instrument oftener than once every four days, or every week. If you persevere patiently you will finally succeed completely in reducing the displacement.

Before letting the woman go away to-day I am going to introduce a pessary. I do not believe in beginning with a ring pessary in such a case. Of all pessaries the ring pessary is the most liable to do harm. Another point: Do not put in too large a pessary when treating cases like this. If the pessary be too large it may ulcerate into the walls of the vagina, and become so firmly fixed there that it will have to be cut out. I have had several cases where the pessary rested in a grooved ulcer and the skin had united over the rim. When such an accident happens, the best thing, perhaps, that you can do is to get a pair of bone forceps and cut up the pessary in pieces, and so remove it from its bed.

The best pessary for this case is a Hodge, or Smith's modification. Be sure to impress upon the patient if at any time she finds herself unable to remove the pessary, that she send at once for a physician.

THE DIAGNOSIS OF OVARIAN CYSTS.

The patient is married, but sterile. You notice the very marked swelling on the left side of the abdomen. The patient first noticed this enlargement during an attack of dysentery. Since that time the tumour has constantly increased in size. After a careful examination I have diagnosed this tumor to be a cystic degeneration of the ovary. As I find that the womb is pushed over to the right, I should say the left ovary was diseased.

What is an ovarian cyst? The ovaries, as you know, produce the Graafian follicle, which is a little cyst. Some say that one of these follicles enlarges, degenerates, and so forms a cyst. This would account for the origin of a unilocular cyst. When the cyst is multilocular it is supposed that several of the follicles become cystic, that some one overlaps and includes the others, which thus form children cysts. Other physicians and pathologists hold that the substance proper of the ovary degenerates and becomes cystic. I think that the first theory is the more plausible of the two.

A cyst of the ovary very rarely occurs after menstrual life. It is very likely, however, to affect women who are sterile. There are three kinds of ovarian cysts, the monocyst, the oligocyst, and the polycyst.

Ovarian cyst is to be distinguished from dropsy in the following manner: In a case of ascites, the abdomen, when the patient is placed on her back, is flat on top and bulges out at the sides. Here there is a projection on top and not so much bulging out at the sides. In ascites, the intestines float up to the top, and we get resonance

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upon percussion. Here percussion, both superficial and deep, reveals only flatness. In cases of ascites, when the fluid is allowed to settle. there is usually resonance on the top of the abdomen, and dense flatness at the sides. Here there is quite appreciable resonance on the sides.

Examination of the external genitals, vagina, womb and breasts, which have withered, excludes the possibility of pregnancy.

There is one most certain way of settling the question, and that is by means of the aspirator. The fluid of ascites is straw-colored and limpid; that of a monocyst is perfectly clear and limpid, like spring water; that of a polycyst is thick, dark and turbid, from disintegrated red blood corpuscles; that of an oligocyst, which I suspect this to be, is usually of a milk and water, or of a light brown color. I should not think of tapping a polycyst unless I were ready to proceed at once to operate. The fluid is so intensely acrid and irritating that the escape of a few drops into the peritoneal cavity might set up a violent peritonitis, and rapidly destroy life.

I make the puncture in this case in the linea alba, half way between the umbilicus and the symphysis pubis. The fluid here is, you see, of a medium brown color. I shall send a part of this liquid to Professor Tyson for microscopic examination, and if he finds any of the Drysdale ovarian cells in it, I shall be confident that we have here an oligocyst.

ORIGINAL ARTICLES.

PULVIS ARSENICOSUS ASIATICUS.

BY

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Professor of Dermatology in the University Medical College, New York.

PULVIS ARSENICOSUS ASIATICUS.

The well known "Asiatic pills," composed of arsenious acid and black pepper, enjoy a high repute in Europe in the treatment of certain cutaneous and malarial affections. They are occasionally employed in this country, but not so frequently as abroad. Personally I have found them, as obtained on prescriptions, very uncertain. The cause of this was not clear until I found that there were in use several different formulas for their preparation.

Cazenave gives the following:

℞	Of arsenious acid.	gr. lv
	Of black pepper in powder,	3 ix
M.	and make 800 pills,	

The French Pharmacopœia directs that they shall be made as follows:

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"PILULES ASIATIQUES.

		Grammes.
℞	Acide Arsénieux porphyrisé,	0.50
	Poivre noir en poudre très-fine,	5.00
	Gomme Arabique pulvérisée,	1.00
	Eau distillée,	q. s.

Mettez l'acide arsénieux dans une mortier de porcelaine; ajoutez-y peu à peu, en triturant longtemps et avec précaution, le poivre et la gomme, de maniére a obtenir un melange tres-intime. Ajoutez la quantite d'eau nécessaire pour former une masse de consistance convenable: Devisez la masse en cent pilules, dont chacune contient. o gr. .005 d'acide arsénieux."

In Germany the Asiatic pill is not officinal, but is prepared according to formulas differing from the foregoing. Lastly, I have been informed that many of the Asiatic pills sold in this country contain no arsenic at all. Under these circumstances it is not surprising that they have fallen into disuse. Believing, however, that the combination is "too good to be lost." I have had the following prepared:

PULV. ARSEN. ASIAT.

℞.

Acidi arseniosi, 2 parts.
Pulv. pip. nig., 20 "
Sacch. lactis, 78 "

M. Tere bene secundum artem.

To obtain a good preparation it is essential that the mixed powders should be very thoroughly triturated, as directed in the French Pharmacopœia, and it is specially requisite that the arsenic should be equally diffused throughout the mass. To accomplish this successfully, one-third of the sugar should be mixed with the arsenic, rubbed and mixed for at least twenty minutes; a second third of the sugar should then be added and manipulated for twenty minutes more; afterward the rest of the sugar and the pepper should be added and rubbed with the rest for an additional twenty minutes.

The powder thus made, according to the formulas given, can afterward be made into pills, compressed or not, of any desired size, or it may be dispensed in the form of powder. In the latter case it cannot be comfortably taken, either dry on the tongue or in water, on account of the hotness of the pepper. To remedy this, however, I have sometimes directed patients to keep their powders in the dining-room, and at each meal to put the dose upon their plate and to use the "medicated pepper" in the same manner as they would the ordinary non-medicated condiment. This powder is kept on hand and compressed by F. A. Reichardt, 404 Fourth Avenue, New York.

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TRANSLATIONS.

REMARKS ON GONORRHŒAL ARTICULAR RHEUMATISM,

Delivered at the Hospital La Charite,

BY

M. HARDY.

(Gazette des Hopitaux.)

We have at present in our service in the hospital a man of thirty-two years of age, a cook, who has had a number of attacks of gonorrhœa, one of these during the last year. It presented this peculiarity, that in the course of the disease, and even at the commencement, it was accompanied by a painful swelling of the two knees, which, after having persisted for several weeks disappeared without leaving any traces.

Four months ago, this man having contracted a new gonorrhœa, he was taken, as in the previous instance, about fifteen days after the commencement of the running, with intense pains, having for their seat the tibio-tarsal and metatarsal articulations of the two feet. These pains were so severe, that for two months, the patient was not able to walk. After that they disappeared, and the discharge, which during their manifestation was suppressed, then commenced afresh. From that time the man was able to perform his duties, but at the end of eight or ten days, whether through improper hard work and fatigue, or from the influence of being chilled, the pains re-appeared in the articulations and compelled him to enter the hospital.

At our visit we discovered the following state: The patient is pale, markedly anæmic, and shows a slightly cachectic hue. In the feet, and particularly in the left foot, the tibio-tarsal and meta-tarsal articulations are the seat of a very marked swelling; they are, moreover, extremely painful, both when he remains quiet and when he walks, but worse when he walks. There is no febrile movement of any account, the pulse is normal, the digestive functions are entirely natural; no cough; indeed, nothing appreciable in the different organs except a very slight proportion of albumen in the urine.

From the presence of these signs and symptoms, it is evident that we have to deal with that variety of arthritis which has been designated by the name of gonorrhœal rheumatism. But, aside from this affection, there exists another which is indicated by the presence of albumen in the urine, as well as by the pallor and profound anæmia of which this man bears the marks. This affection is no other than a nephritis, which, and above all parenchymatous nephritis, is, indeed, a sufficiently frequent complication of gonorrhœa. It results from the propagation to the kidney of the inflammation that is seated in the urethra.

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The treatment on which we have placed this patient consists simply in the administration of the salicylate of soda, so much praised at the present time for the treatment of articular pains. During the last forty-eight hours, he has taken each day, in one portion, six grammes (a drachm and a half) of this substance. Since then the swelling has decreased, the pains during rest are less severe than before, but those that occur when he walks are just as aggravated. In fine, the slight ameliorations that we have obtained seem to be more the consequence of the rest than of medication, and the salicylate of soda does not seem to give, in gonorrhœal rheumatism, the improvements which we have obtained from this substance in the treatment of true articular rheumatism, inflammatory in character and generalized.

It was not so very long ago that the attention of physicians was called, for the first time, to gonorrhœal rheumatism. It was, indeed, only at the end of the last century, in 1781, that the relation that exists between certain articular pains and gonorrhœa was remarked upon. Hunter, at first, later Ricord, Rollet, and Fournier were those who contributed the most to make the affection a particular nosological entity.

Gonorrhœal rheumatism, like articular rheumatism, is particularly characterized by pains, sometimes very slight and occurring only during walking, at others extremely severe and persisting, even during repose. The articulations attacked by gonorrhœal rheumatism are, moreover, the seat of swelling, and often present an enormous effusion that may sometimes simulate a true hydrarthrosis.

As regards the erythematous redness so evident sometimes in acute articular rheumatism over with the diseased joints, it is rare in the variety that now occupies our attention.

Gonorrhœal rheumatism seems to have a marked predilection for the large articulations, and notably for the knee. Following, in order of frequency are the articulations of the wrist, the foot, the shoulder, the fingers and the toes, and the tarsal and metatarsal.

But it is not always limited to the articulations. It is for this very reason that I prefer to call it rheumatism rather than arthritis, as certain authors have proposed. Sometimes, indeed, it is in the sheath of the tendons that it develops itself, as those of the wrist, for example, or the foot; again it may be in the tendo Achillis or the tendon of the patella.

At other times it is in the tendinous bursæ, more rarely in the sciatic nerve (Fournier), sometimes on one side, sometimes on the other, and even in the two at the same time.

At the same time that the disease occupies the different parts of the body, we frequently see divers accidents happen to the eye, such as intense conjunctivitis with purulent secretion, or even a keratitis with accompanying iritis; analogous phenomena to those that are observed in this organ in the course of ordinary rheumatism.

The number of articulations affected by gonorrhœal rheumatism is very different from the number involved in febrile rheumatism. So

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much so, indeed, that the latter has a very great tendency to attack many articulations, sometimes even all the joints in the body, while it is rare to see the variety we are now studying occupy more than one, two, or, perhaps, three or four articulations; it is rarer still to see these taken one after another, as is the rule in the former disease.

Gonorrhœal rheumatism is, in general, apyretic, and in this again it differs from the preceding kind, so that if, at the commencement, under some circumstances, we observe a slight febrile movement, it is always very moderate and does not last longer than two or three days.

In the same way, contrary to what is seen in acute articular rheumatism, the increase in perspiration amounts to nothing, or very nearly so. Finally the urine does not exhibit any of those alterations that characterize ordinary rheumatic cases; it is neither frothy, nor cloudy, nor turbid. In ordinary rheumatism, as is well known, the urine is always characterized by the presence in larger proportion than customary, of the urates, uric acid, and urea. Finally, gonorrhœal arthritis is not complicated as is acute articular rheumatism with cardiac affections, so frequent, on the contrary, in the inflammatory form.

Relatively to its termination we find, in the same way, in the disease which is made the subject of this lecture, something peculiar. Indeed, after having lasted several weeks, or several months, cure is ordinarily the rule; but it may also happen that the articulation, although deserted by the disease, remains painful; sometimes even it occurs that it may be the point of departure for a true hydrarthrosis, or even a white swelling, which will terminate in anchylosis. Anchylosis, moreover, may become established without this last complication.

As regards its etiology, we shall say that in order to have gonorrhœal rheumatism we must have, as an essential condition, the existence of gonorrhœa; but this does not suffice; it is yet requisite, in order to be affected, that the subject should have a special disposition, which is not, as some have wished to establish, a certain tendency to the rheumatic diathesis. Ask, indeed, those patients who cannot have gonorrhœa without immediately seeing one or more of their articulations become the seat of the phenomena with which I have made you acquainted, and they will invariably reply to you, that except with gonorrhœa their joints are always perfectly free, and that they are not the subjects, after catching cold, to contract muscular or articular pains.

We do not know anything positive relative to the epoch at which gonorrhœal rheumatism appears. All that we can say is that sometimes it appears at the commencement of the urethral affection, and sometimes only one, two, three or four days after the first symptoms of the disease. There is the same uncertainty about the influence which the gonorrhœa exerts on the intensity of the articular pains. It has been asserted, it is true, that those cases are the most severe in which the discharge is the most abundant, but they are just as bad in acute or sub-acute gonorrhœa as in that which is characterized by only a slight discharge.

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At the time of the appearance of the articular phenomena, it is not rare to see the gonorrhœa arrested at once, to become aggravated again after the cure of the rheumatism. It seems as if there were a true metastasis, like a transportation of the morbific materials from one place to the other. This phenomenon is far from being constant, but it is quite ordinary to observe that, with the arrival of the rheumatism, there is a certain diminution of the discharge.

In view of these considerations the disease requires a treatment altogether special. Indeed, gonorrhœal rheumatism being a local affection altogether, and not accompanied by general phenomena, we may conceive that measures which have a purely local action should alone be used in the treatment of this affection. We should, therefore, at the commencement, have recourse to applications to the diseased parts, leeches, wet cups, cataplasms, and if the disease has a tendency to continue, we may employ blisters. Finally, later on, if the gonorrhœal rheumatism has a tendency to take a chronic course, we will find employment of baths, of douches, of thermal mineral waters, salines or alkalines, of some slight value; in a word, the different methods by means of which we combat chronic rheumatism.

F. A. L.

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WRY NECK OF INFANTILE ORIGIN IN THE ADULT.

BY

MR. F. R. FISHER.

(*The Lancet*, October 27, 1877.

A young woman, aged 21, came under Mr. Fisher's care in the National Orthopædic Hospital, whose history included a spastic contraction of the sternocleido mastoid muscle on the left side. At birth no deformity was noticed, but between six weeks and nine months severe convulsive fits occurred. At this latter period the head was observed to be slightly out of the straight line, and though surgical opinions were obtained at that time, and later, at 8 years, nothing was advised. At 20, instrumental treatment was commenced, and continued for 10 months without relief. When she applied at the hospital the left sterno mastoid was very rigid and strongly contracted;

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the right much atrophied. On measurement the left mastoid process was $3\frac{1}{4}$ inches from the left sterno-clavicular joint, the distance between the corresponding points on the right side was $6\frac{1}{4}$. The left side of the face was smaller than the right, and by contrast appeared wasted. The left features were dragged down below the level of the corresponding ones on the opposite side of the face; the upper jaw rotated to the right and pushed forwards, and the upper and lower incisors could not be brought into apposition. There was severe rotatory curvature of the spine in the cervical region, with a long compensatory curve in the dorsal, and a shorter one in the lumbar region.

On July 13th Mr. Fisher divided the left sternocleido-mastoid muscle, placed the patient in bed for one week, and then commenced the mechanical treatment, using Mr. William Adams' instrument. At the end of five months there was a scarcely appreciable difference between the measurements on the right and left sides. The position of the head was most satisfactory.

A few months subsequently great improvement was noticed in the distortion of the face, the obliquity of the features, the approximation of the lower and upper incisors, the position of the lower jaw, and in the spinal curvature. N. M. S.

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THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY.

A WEEKLY JOURNAL OF MEDICINE, SURGERY AND THE COLLATERAL SCIENCES.

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EDITORIAL.

THE WOMAN'S HOSPITAL.

The vacancy in the surgical staff of the Woman's Hospital, caused by the recent death of Dr. Peaslee, has been filled by the appointment of Dr. N. Bozeman, of this city. Of all the applicants for such an important position—and we doubt not there were many—the Board of Managers could not have selected one more fit in every way to fill the gap left by the decease of so eminent a man as the late Dr. Peaslee. We understand that it has long been the greatest aim and most cherished desire of the present incumbent to gain the place that he has at last obtained, and though he has been so long unjustly kept from his due, we have no doubt he will fill his place with credit to himself and satisfaction to the profession.

When the Woman's Hospital was first founded, its original object was for the treatment of vesico-vaginal fistulæ—that terrible disease

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for which a successful method of treatment had but then been discovered. Dr. J. Marion Sims had just come to our city, and, filled with glowing enthusiasm about his novel methods, enlisted the sympathies of the profession and many of the wealthy laity in favor of his projects. It was the original idea of the founders of the hospital to establish an institution for the purpose of treating vesico-vaginal fistulæ, and at first it was almost exclusively devoted to the unhappy sufferers from that formidable disease. But gradually its scope was enlarged, and women with other diseases were admitted to its benefits.

Dr. Bozeman was, from the very first, identified with the new methods of treating this affection, and though we have no desire to say a single word on either side as regards the controversy between him and Dr. Sims, concerning the question of originality or priority, we must admit that Dr. Bozeman has attained a fame second to none in the treatment of the disease.

It is rather strange that though the methods of successful treatment of this malady have now been so long before the profession of this country, nay, the profession all over the world, that there have been no operators who have been able to meet with the same success as Dr. Sims, Dr. Bozeman, and one other, Dr. Emmet. These three surgeons are, without doubt, the most skillful in the world in treating the disease, and they stand alone without a rival. There are undoubtedly other able men who have attained some success, but these three gentlemen have devoted their whole lives to the study of this particular disease, and there is a deep and wide gulf separating them from others who have followed in their footsteps. Dr. Bozeman has devoted the energy of a lifetime to the perfection of his methods, and he has given to the world as much as any man in this department of surgery. It must be admitted that he has never received proper support and appreciation from the profession, while, had he obtained it, he might to-day be, perhaps, in as eminent a position as some of his more successful rivals. It is much to be regretted that Dr. Bozeman has never before had the real opportunities that are now opened to him, and no one will deny that he is now receiving nothing but his just rights, that should have been tendered to him long ago. In concluding, we can only reiterate that the appointment is the very best one that could have been made, and congratulate Dr. Bozeman on receiving at last some slight acknowledgment of his invaluable services to the profession and to suffering humanity.

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LECTURES.

LECTURES ON PARALYSIS AND CONVULSIONS AS EFFECTS OF ORGANIC DISEASE OF THE BRAIN.

Delivered at Bellevue Hospital Medical College, New York,

BY

C. E. BROWN-SEQUARD, M.D., ETC.

LECTURE VIII.—CONCLUSION.

GENTLEMEN:—Yesterday, you will remember, I was speaking of loss of consciousness as an effect of a peculiar alteration in the circulation of the brain. I proposed long ago to explain the loss of consciousness that occurs in an attack of epilepsy by attributing it to the contraction of the blood vessels in the cerebral lobes. Contraction does take place; and it is a part of the epileptic attack. The same thing occurs in the blood vessels of the face, and the face becomes pale. There is no doubt that a spasm of the muscular walls of the blood vessels exists in the beginning of all attacks of epilepsy.

Although theoretically the cerebral convolutions contain the organs of consciousness, the will, and the mental faculties; although the contraction of the blood vessels is clearly a cause of the cessation of cerebral activity, and there is no doubt that the cessation of circulation exists, it is certain, also, that it is not simply on account of this cessation of circulation that the loss of consciousness occurs.

In the first place, if we galvanize the two sympathetic nerves of the neck, thereby producing the greatest contraction that can take place, causing complete cessation of the circulation in the convolutions of the brain, we do not find that this condition alone is sufficient to produce loss of consciousness. There is certainly disorder in the animal's brain, but there is no complete loss of consciousness.

Secondly, if we cut the four large vessels that supply the brain, arresting the circulation at once, the loss of consciousness is never immediate. In most attacks of epilepsy the loss of consciousness is immediate. In some individuals there is no appreciable time between the aura and the loss of consciousness. So the loss of consciousness takes place before the cessation of the circulation can have time to produce its effects. We cannot, therefore, look upon the contraction of the blood vessels as the cause of the loss of consciousness.

I call your attention—especially those of you who are desirous of making investigations—to the fact, that it is not even certain that the view we all entertain is correct,—that the function of an organ is lost, especially in the brain, when the circulation in that organ

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stops. There are facts that are in opposition. In cholera, for instance, the circulation in the brain is at times almost *nil.* After death the blood is found exceedingly black, and frequently congealed; it does not contain any marked amount of oxygen; certainly, infinitely less than is essential for its nutrition, yet the activity of the brain may continue for days without a diminution of the mental power.

I know that we can explain this fact otherwise than by adm.tting that a certain amount of nutrition is necessary for the activity iof the tissues. It can be said that in cholera a poison exists in the blood that may serve for the nutrition of the brain, but such a supposition is absurd. However, it is the only way in which to explain the fact that the brain can go on with its activities, without nourishment from the ordinary constituents of the blood that nourish it in ordinary circumstances.

When a man or animal is decapitated, death takes place, and the brain is immediately emptied of its blood. In that case as well as in the case in which we cut the four large vessels, there is no circulation in the brain, and we all admit that it is owing to the want of blood in the brain that that organ ceases to act. That view is not entirely correct. Why should the brain retain its activity in cholera with such a condition of the blood as exists in that disease? Why then, when a man is bled to death should the cerebrum cease to act, simply because there is no circulation there? We must admit that the causes, whatever they are, that produce contraction of the blood vessels of the brain, also at the same time cause an irritation which stops the activity of the brain, just as when we prick the medulla oblongata the animal falls down with loss of power, and the heart ceases to act, but the activity of the brain is lost, without change in its circulation. Suppose the heart continued to beat and the respirations continued, there would still be circulation, but the cerebral activity is lost. A change can immediately take place in the brain so complete as to stop its action instantly.

The action is like galvanism of the par vagum, producing stoppage of the heart. Certain cells in the brain are stopped in their activity by the irritation. If these facts be so, you can easily understand how it is that in cholera, though the blood ceases to circulate, there is no loss of consciousness, for there is no irritation to interfere with the activity of the cells. When you cut the vessels some irritation is started, which stops the activity of the brain cells.

I bring these points up to show you that a great deal yet remains to be investigated concerning them and many others.

We all admit that muscular irritability diminishes when the muscles are not used. The muscles certainly waste away when they are not used, but this wasting may be due to some other cause than the mere rest. There may be an irritation that alters the nutrition. In hysteria, for instance, the irritability may not be altered when there is complete paralysis. I once saw a young lady from London whose right arm was completely paralyzed, and in which there had been no

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movement for two years. The muscles were just as well nourished and responded as easily to galvanic stimulation as those of the other or healthy arm. There had been absolute rest, except perhaps slight movements during sleep, so that muscular inactivity is not in itself a sufficient cause of wasting. Wasting comes from an irritation that produces changes in nutrition. Thus in some cases of disease of the brain or spinal cord the muscles waste away very quickly. I have seen the muscles reduced to half their normal size in a week. If there is muscular wasting, you may be sure that there is some secondary change in the brain and spinal cord. I bring these points out thus prominently on account of the seeming difficulty in distinguishing a simple cessation of activity, and a loss of power. The symptoms in disease almost always appear from an irritation that causes or stops activity.

Returning to loss of consciousness, I will say in regard to attacks of epilepsy, of syncope from emotion, or loss of consciousness due to poisons, as morphia or other narcotic remedies, it is due to cessation of activity. When rapid cessation of activity of the brain is produced it is sure to be due to an inhibitory influence of the same kind as we get when we prick the medulla oblongata. There is an inhibition of cell activity, which may last or not according to circumstances.

I now pass to another point. I said yesterday that there is very frequently, in cases of convulsions due to brain disease, an aura. It is important, if possible, to find this out, for if you discover the aura you may have means of stopping the attack. In this way you may not only stop one single attack, but a series of attacks, for each attack of the kind produces changes that predispose to another attack.

Now, as regards our means of preventing an attack. For centuries past, means have been resorted to for preventing the occurrence of these attacks. Galen proposed to put ligatures on the limbs for this purpose. Suppose, for instance, that the aura was in the finger. Galen and many others applied a ligature to the arm, with the idea that there was something which was going to pass from the finger up the arm to the brain, and there produce disorder. Such an idea is, of course, absolutely false. We very frequently succeed with a ligature on the arm, when the aura is there, in preventing epileptic attacks, but not because we prevent the passing of something to the brain. In reality we send an irritation to the brain which stops an irritation already there, and which, if undisturbed, would cause the attack. It is the same thing as in disease of the spinal cord, where, when we take hold of the big toe and press it downward, we sometimes stop convulsions that were beginning to appear in the lower limb.

In spinal epilepsy the convulsions are often very violent, and may be produced by the slightest touch. In many of these cases, especially in certain forms, we may often produce complete relaxation of all the muscles, by this simple procedure, simply pulling down the great toe. There is an arrest of the morbid action of the cells in the spinal cord produced by irritation of the nerves in the joint of the

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big toe. Whenever convulsions exist you can witness these results of irritation.

The same thing may happen when the disease is in the brain, as well as when it is in the spinal cord. Disease in the brain produces sometimes muscular contractions and sometimes sensations. It is just the same as when pressure on the ulnar nerve, or funny bone as it is called, causes a sensation in the fingers. A ligature, in the cases we have mentioned, is not essential, a simple pressure may be sufficient.

As soon as I came to hold the view that it was the irritation of the skin that stopped the convulsion, I tried other means to produce the same effect. Extreme cold, as the pressure of a lump of ice to the part, or heat, or pinching, may be sufficient to arrest the attack where the aura is known. Patients, often, are able themselves, by moving the limb rapidly, as soon as the aura comes on, to stop an attack. An irritation at the periphery may act on the brain and stop the convulsion. This irritation may even succeed when it is applied to the other side from that on which the aura occurs, so that an irritation starting from any point, but especially near the locality of the aura, may sometimes stop the convulsion.

As regards other forms, if an aura starts from the stomach, anything which irritates it, as a strong emetic or a purgative that will exert rapid action on the stomach and intestinal muscles, may ward off the epileptic seizure. Pressure on the abdomen or a galvanic shock may prevent the attack in many cases.

If the patient have simply an undefined sensation of uneasiness, with no distinct place in which the aura originates, an irritation of the skin of the neck or between the shoulders, may be of service. Irritation may be made in the form of a lump of ice, a blow, a galvanic shock, etc. These means may be varied almost infinitely. Any medicine which acts with great power on the stomach or bowels, or upon the nervous system, may be of benefit in such cases.

A good ordinary remedy is three or four grains of carbonate of ammonia in a drachm or a drachm and a half of tincture of columba or gentian. Taken pure it is perhaps too strong, and may burn the throat, but it may be diluted. Such a dose may arrest an attack, but it must be taken immediately.

Running, jumping, etc.—anything that may produce a change in the circulation—may be of service in cutting short an attack. You cannot know *a priori* which means will best work on the patient, but looking carefully, and trying one after another the various means, you may find the one best suited to the case. If you save the patient from one attack, you may save him from a great many, and perhaps in this way, cure him entirely.

The combination of three medicines together, I have found to have considerable more power than the use of one or two of them alone. If you use the bromide of potassium you must use it with the bromide of sodium or ammonium, or the iodide of potassium

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or ammonium. They act thus with far greater power than when uncombined. It is essential to add the ammonium bromide when the other bromides are employed. It is also essential to have some means of counter-irritation applied at the place of the aura. When the aura starts in the finger I have applied a circular blister, like a ligature. A blister over the forearm is sometimes useful. In two cases I have succeeded wonderfully by applying a blister around the finger. One of these cases was published in the *London Medical Times* in 1861.

There is, therefore, a series of means which can prove successful in preventing attacks in these cases. Now, as I said in the last lecture, if we have a means by which we can do so much in controlling epilepsy, why should we not be able to do the same in paralysis, which is essentially the same in its method of production.

I now come to speak of this point more particularly, but before doing so, I have to say a few words more as regards the doctrine of the production of paralysis and convulsions now advanced, and of those I have to substitute in place of the generally admitted theories.

The facts that I have mentioned in my lectures seem to be quite in opposition to the views held by most, if not all, physicians. When, for example, paralysis exists in the right arm, and disease is found in the left convolutions, it is admitted that the centers of will power have been destroyed, and it is natural for the arm to be paralyzed. In the same way if we cause irritation in any part of the voluntary motor apparatus, as the convolutions, and slightly inflame them, and the patient is attacked with convulsions in the right arm, it is quite natural according to the accepted theories, to look upon the irritation there as having produced the convulsions, and having put into play the activities of the part in which the irritation exists. These two cases of paralysis on the one hand, and convulsions on the other, seem to be in perfect harmony with what is thought to be established. But, as I have said many times, we may not only find the same thing taking place upon the opposite side, but upon the same side as the disease. The theory cannot apply in such cases. Besides, we may see the same thing when the disease commences in those parts of the brain, which will not produce movements when galvanized, and which do not belong to the voluntary motor apparatus.

Take, for example, the posterior lobes, disease in which, according to the admitted theories, should never produce paralysis or convulsions, but it does often produce paralysis and convulsions. What are the explanations given by physicians and physiologists of these cases which are against their views? They have been very few and very timid, and I think that I myself have put forward these explanations very strongly in opposing the admitted theories. Some of these cases may be explained by my view. It is quite evident that when we make an autopsy in a case in which there have been both paralysis and convulsions and find disease in the posterior lobe of the brain on the opposite side, that the disease is situated there. We are absolutely certain

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that the disease is at that point. It may be said what proof is there that there is no disease elsewhere? There may be disease in the voluntary motor apparatus which is undetected when we examine in the way we usually do at an autopsy. We cannot spend days in examining every minute part of the brain tissue with the microscope.

There are many cases which answer this objection. If we find a patient stricken down with symptoms of hæmorrhage in the brain. He had no evidence of brain disorder previous to this attack, which occurs suddenly. He has paralysis and convulsions in the right arm, and he dies within a few hours, as such may be the case, with a very limited hæmorrhage. We make the autopsy and find the posterior lobe to be the seat of the hæmorrhage. Can you admit that there was disease elsewhere? What kind of a disease could have been produced so quickly, or could have produced the paralysis found in the arm, at the same time as the symptoms of hæmorrhage occurred. In such a case we cannot say that the symptoms depended on some other disease that we do not see. Why should not the same thing apply when the paralysis and convulsions are on the side of the body on which they ought to be, according to the admitted theories?

There are a great many cases besides hæmorrhage which prove the same thing. Embolism of the arteries may act in the same way. In such a case the autopsy shows nothing else besides the embolism and surrounding congestion. If the lesion is in a part which does not belong to the voluntary motor apparatus we must admit that the paralysis and convulsions were due to the disease we see and not to one that we can only imagine. Other instances yet might be given, but time presses and I will not go into them.

There is still another series of explanations which is very much needed to sustain the admitted theories. For instance, when the disease is located in a part, and sometimes a large part of the supposed voluntary motor apparatus, and there is neither paralysis nor convulsions. How is it they have not been present? It might be said,—I do not say it has been said,—that paralysis has not appeared because only a part of the voluntary motor apparatus is destroyed. It may be, and it is so in some cases where the disease is slight in extent. But how is it that there may be no paralysis and convulsions when a great part of the voluntary motor apparatus is destroyed. Then it might be said that, though apparently diseased, enough tissue is left to transmit impulses, and be able to act. In softening after embolism, it may be that the nervous tissue remains active, although it has undergone considerable alteration. The same thing may be true likewise in cases of tumors causing pressure on the brain. There may be simple atrophy of tissue without any loss of function.

This explanation will pass for a number of cases. It is certain that nerve fibres have as an essential element, the cylinder axis, and this part may remain active though there is pressure on it. It may be so, but it is not at all proven; and, then, what of those cases in which every part

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of the nervous tissue, axis cylinder and all has been entirely destroyed? There are forty or fifty of such cases in which disease has struck the base of the brain, or the convolutions, and in which no tissue was present that was not completely eaten up by the disease. We should expect not only loss of function, but that loss of function should be complete.

There are, then, two kinds of cases, those in which the tissue is altered, and those in which the tissue is not there. In a number of such cases there has been no paralysis and no convulsions. It is clear, therefore, that there are a great many facts which cannot be explained by, and which are in direct opposition to the generally admitted views.

What then is the theory which we are to admit in place of the generally accepted views as regards the production of paralysis and convulsions?

I have already often said that paralysis and convulsions appear from a mechanism alike in both cases, no matter how different one symptom is from the other. If you admit, as I do, that the cells of gray matter of the brain are endowed with different functions, then the explanation is easy. The cells which serve for moving the right arm are scattered in the brain, as well as are the cells that serve for any special function of the brain. These scattered cells belonging to any particular function, are connected together by fibres, so as to be enabled to act in harmony with one another.

Suppose that the cells being so distributed, an irritation comes from the bowels in a certain individual, the irritation is transmitted to certain parts, and instead of going to certain other parts, it meets, in the part to which it has been transmitted, either with cells that are able to produce voluntary movement, or those which are able to produce movements by reflex action. These are different kinds of cells that have two distinct kinds of actions as many facts show. If the irritation goes to cells capable of producing voluntary motion of the arm, for instance, that irritation produces the same effect when it strikes those cells as would an irritation of the *par vagum* by galvanism produce on the heart. The cells are inhibited and the heart ceases to beat, and just so these cells that move the arm have their activity suppressed, and paralysis occurs. If, however, an irritation starting from the bowels acts on those cells which serve for the production of reflex movements, whether they be in the base of the brain or elsewhere, these cells are put in play and convulsions occur. Identically the same phenomena occur when there is disease in the brain itself, as when the irritation starts from the bowels.

An irritation starts from the posterior lobes, for instance, it spreads in the brain, and there acts on those parts that have a morbid sensibility. They would not be so acted upon if they were in a normal condition. If these cells, wherever they are, are those that serve for the production of voluntary motion, as for the arm, they are inhibited in their action, and paralysis of the arm is the result. If, on the con-

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trary, the irritation, originated at the same place, reaches cells that have the power of producing reflex action, convulsions will be produced. There is the same element in both cases; there is an irritation starting from a particular place and traveling to cells at a distance; there the irritation causes an inhibition or an excited activity and produces either paralysis or convulsions.

If you pass in review all the facts that I have given you, and what you will observe for yourselves, you will see that there is nothing that cannot be explained by this theory

Take an irritation starting from this same posterior lobe, and exerting an action on those cells that serve for the production of speech. The centre for this faculty, according to the old views, lies far from the starting point of the irritation The irritation is spread and reaches the cells in a more or less morbid state, inhabits their action, and aphasia appears.

I have not time to dwell longer on my opinions to make them better understood, but I will simply say that paralysis, aphasia, or loss of function in any part of the brain, can occur by attacks, as well as convulsions can occur in attacks. This is in perfect harmony with the views I hold.

The vision, the hearing, the expression of ideas by speech, voluntary motion of the arm, leg and so on, may be affected with paralysis by attacks. Not only in cases of paralyses of this kind that occur in attacks, but also in those cases where the paralysis persists, there exists something of this kind of action. The objection to this would be: how is it that such a power can be kept inactive for so long a time as the inactivity exists when the paralysis is persistent. In many cases, however, of paralysis from organic disease of the brain there has been a sudden change for the better. Some cases have even been quite cured, while the same severe lesion that produced the paralysis persisted. And so it is in any case, in loss of any function of the brain, although an organic disease that causes paralysis continues to exist, the paralysis disappears.

So then it is proven that paralysis, or amaurosis, or aphasia, or any other loss of function does not depend on the destruction or loss of brain tissue.

We know perfectly well that we can produce in animals in many instances the arrest of an activity of cells, not only in the heart or respiration, by irritation of certain portions of the base of the brain, but in other functions. So we know clinically that an irritation in the bowels may produce an arrest of activity in the cells that serve for sight. By irritation we may arrest the activity of the cells that serve for sight, or for any or all the mental faculties, the will, and indeed any nervous activity, may be suddenly arrested by irritation.

There are two cases on record of hæmorrhage in the upper part of the spinal cord, parts from which there could be no pressure exerted on the brain, in which loss of consciousness occurred. There was loss of power of all the functions of the brain, motion, sensation and

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will power, and certainly there was no pressure on the brain, but simply an irritation started from a distance. In these cases consciousness was recovered.

Sometimes we may produce death rapidly, and therefore stop all activity of the brain, by a mere prick. We can also produce a persistent amaurosis by a mere prick of the corpus restiformis. There is no direct connection between this body and the eye, and nevertheless the amaurosis persists while the animal lives. I have had an animal live in my laboratory, with loss of sight produced in this way, for two years after the injury. After a time an alteration in the retina occurred, but this was long afterward.

We can also produce loss of all sensibility and of all the will power by a mere prick in the spinal cord. In some cases we may produce in this way anæsthesia on the opposite side of the body and loss of will power on the same side.

In some cases of disease of the brain, the pulse is weakened and irregular while the patient lives. This is due to an arrest of the action of the heart from the disease in the brain. If the action of the heart can be so persistently modified, why may not different regions of the brain be affected in a similar way.

In disease of the brain, in a like manner, the reflex activity of the cells in the spinal cord may be inhibited. The sphincters of the rectum and bladder may be permanetly paralyzed. The same thing may take place in the cells that control voluntary movements.

Now, from what has been said, what are the conclusions reached as regards treatment? As my time is over, I can only say a few words. The principal point is, that you are to fight disease of the brain by means of irritation applied to the skin in the parts affected. Suppose, for instance, the arm is paralyzed, then apply the irritation so as to restore the activity of those cells that serve for voluntary motion of that limb. Place the irritation directly on the parts affected. The same means may be applied to the treatment of paralysis as apply to the treatment of an aura. Metallic plates applied to the skin will sometimes cure anæsthesia. The passage of a needle might have the same effect. In a few words, the means are to be applied to the parts affected.

CLINICAL LECTURE ON PETIT MAL AND IDIOPATHIC EPILEPSY.

Delivered at the University Hospital, Philadelphia.

BY

H. C. WOOD, JR., M.D.

Professor of Nervous Diseases in the University of Pennsylvania.

M, H.,—12 years of age,—was very high spirited and fond of play when a little child. Of late years has shown a great disposition to mope and keep to herself, avoiding her playmates. She has lately had occasional spells of giddiness. These spells usually occur about

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the middle of the forenoon. The last attack was some six weeks ago, and lasted about an hour. After the attack is over she falls into a deep sleep. Her mother tells me that when these attacks come on the pain in the child's head is excessive, and that her face becomes blanched. Her eyes also present a wild, scared look. Upon close questioning, I find that the child's general health is good, but that the family history is doubtful. The brother of the child's father had frequent fainting fits (probably epileptiform in character), during the course of which he lost consciousness. He would stop talking suddenly, stagger, and fall, and when the fit was over would resume the conversation just where he had dropped it. The father himself seems to have manifested before his death several of the symptoms of incipient insanity. There is a possibility that all the symptoms presented by this little girl are due to the presence of seat worms. Her mother has, however, examined the passages upon several occasions, and has never been able to discover any worms.

Here is another case of the same general nature. This boy has been brought here from a distance by his mother, for the purpose of finding out what is the matter with him. You see that he is at present sleeping very heavily; bringing him up here from the ward has not disturbed him. It requires, indeed, quite violent and persistent shaking to arouse him. He had a severe paroxysm about thirty minutes ago, and this is the condition in which it has left him: a state of deep, heavy sleep. His mother tells us, upon inquiry, that he has been affected in this way for the last four months or so. During that time he has never passed a week without an attack of greater or less severity. When the attack comes on the first symptom noticed is an extreme pallor of the face, followed by redness, loss of consciousness and rigidity, and then the attack passes away for the time being, and leaves the patient utterly overpowered by sleep. He had, as I have said, a convulsion half an hour ago, and the resident physician was able to notice the character of the exact symptoms; first, pallor, then redness, then a tendency to fall down prevented by rigidity, with frothing at the mouth. On questioning the boy's mother, I was enabled to find out that he had one or more convulsions when a baby during dentition. Upon several occasions lately, the attacks have been of a much more pronounced character, resembling true epileptic convulsions.

First, then, as to the nature of these attacks; are they epileptiform or not? Are they idiopathic epilepsy, or epilepsy dependent upon some local point of irritation? There has not been any exposure to the sun; the attacks came on late in May, before the intense heat. The mother states that she knows of no injury ever received by the lad. We know that worms in the alimentary canal are occassionally the cause of attacks, which closely simulate those of epilepsy. The round worm, in particular, and also the tape worm, by the local irritation they cause, will give rise to just such attacks; yet these instances are rare. The mother says that when the boy takes worm medicines his

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condition is for the time relieved. The worm medicines, you know, are often combined with purgatives, which always relieve epileptic symptoms. The patient has not been long enough in the hospital to have the feces examined for worms; moreover, I think it exceedingly likely that in his case the relief was afforded by the purgation effected. Epilepsy is always worse when the bowels are torpid; if worms be the cause of the convulsions they will show themselves very soon, and must be gotten rid of by the use of the proper anthelmintics. I remember an instance in which a tapeworm proved to be the cause of severe pain in the temple.

In epilepsy, as in the present case, the first symptom is always an intense pallor, very brief in duration, and frequently overlooked. No one can simulate the initial intense pallor of the epileptic convulsion, while the succeeding redness of the visage can be very easily produced by excessive muscular effort. Accompanying the redness of the face in epilepsy is a furious muscular activity. This boy has had one or two well-marked epileptic convulsions. In petit mal, one of the most obstinate forms of epilepsy, a peculiar symptom is the sudden stoppage of the patient in the middle of a sentence, which, in a moment, is again taken up and concluded. This momentary loss of consciousness may be exceedingly slight; the sentence is picked up exactly where it was dropped. As a proof of this strange psychological necessity, the case is reported of a boy who was just about to take a bite out of a piece of pie when attacked. The first thing he did upon upon recovering consciousness was to complete the act. If the attack is more severe, and the loss of consciousness lasts longer, the patient may fall down. This boy does not fall. Once, when he was out fishing, on a log two feet wide, he had an attack, but did not fall, and so was saved from drowning. As an illustration of the apparent steadying of the nerves in some cases of epilepsy may be mentioned the case of the architect who would run over the most dizzy places when under the influence of an attack.

As regards treatment, of course an anthelmintic must be administered, where there is a possibility of intestinal worms. As a general rule of treatment in epilepsy, all the exciting causes of an attack should be avoided, such as mental excitement, over-eating, indigestible articles of diet. In this case the mother tells me that the free ingestion of milk, or of pie, brings on an attack. As concerns medicinal agents, the bromides are of especial value. The bromides, however, are only controlling remedies; they but rarely cure. In a fresh case, the chances of effecting a cure are, of course, greater than where the disease has been one of long standing. It is said that most of the brilliant cures effected by the use of the bromides are in cases where the attacks are frequent rather than in those in which they only come on after long intervals. In all cases, as a general thing, the free use of the bromides will reduce greatly the number of the attacks. Give at the beginning from 20 to 60 grains thrice, daily, and increase the dose until either the paroxysms stop or bromism makes its appearance. So much for this case.

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To return to the first case. This is undoubtedly an instance of petit mal. This is an excellent example of hereditary neurotic tendencies. In this girl's family there has been a distinct history of insanity. That means a distinct history of imperfect nutrition of the brain—an imperfect development of structure and performance of function. This neurotic imperfection takes the form of insanity in one, of hysteria in another, of bad, vitiated moral character, with criminal impulses, in a third, of epilepsy in a fourth.

I will order this girl put at once upon a regular course of treatment. Her habits of life must be regulated, her physical nature developed. She must avoid all excitement, or strain upon her nervous system. She must be as much as possible in the open air. Her diet should consist largely of farinaceous articles of food. She must go to bed early in the evening. Among medicines, of course, as in the other case, bromide of potassium must be used up to the point of bromism. Never allow yourself to take charge of a case of epilepsy unless it is to be under your charge for six months or more. In a child, epilepsy is in its formative stage. Each paroxysm diminishes the probability of final cure. So never give up your treatment for a moment. You must try and create a habit against attacks.

This child shall have some injections of quassia to remove the seat worms, if any such exist. She had better first have a warm water injection to clean out the bowels, and then half a pint of the infusion of quassia should be thrown into the rectum.

Brown-Sequard believes in mixing all the bromides together in the treatment of this disease. I must say that I cannot agree with him. The bromide of potassium is all that is necessary.

ORIGINAL ARTICLES.

RETENTIVE BUCKLE FOR FRACTURE OF THE LOWER JAW.

BY

JARVIS S. WIGHT, M.D.,

Professor of Surgery in the Long Island College Hospital, Brooklyn, N. Y.

A retentive buckle, to be applied to the top of the head in case of fracture of the lower jaw, may be made as follows:

Cut with pliers a quadrangular piece of wire-cloth, whose length is equal to the distance from the occipital protuberance over the top of the head to the limit of the hair on the forehead of the patient to be treated, and whose width is equal to five meshes of the wire cloth.

The meshes of the wire-cloth must be at least one-half inch square. The wire of which the cloth is made must be about one-tenth of an inch in diameter; and the wire-cloth must be well galvanized, that is, "zinced."

There are five rows of meshes. The middle row and the two outside rows are to remain intact, and the two other rows of meshes are to be operated on as follows: At each end of the quadrangular piece

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of wire-cloth, at a distance of one mesh from the end, and on each side of the middle mesh, cut out with pliers one-fourth of the wire passing from the outside mesh to the middle mesh, leaving three-fourths of the wire projecting inward from the side of the outside mesh. Cut out two or three of these pieces on each side of the middle mesh. And now cut out similar pieces of wire from the corresponding meshes of the middle zone of the piece of wire-cloth. The result will be a double row of buckle tongues—on the sides of the middle row of meshes—and each row of tongues will contain three sets—one at each end, and one in the middle.

Now mould the retentive buckle to the top of the patient's head; then make a soft pad somewhat larger than the buckle. Put the pad on the top of the head, and then place the buckle on the pad.

In the next place, make a six-tailed bandage, with three tails on each end. The middle part of this bandage is to be applied to a suitable sub-mental splint, which supports the fractured lower jaw—an inter-dental splint being used if necessary.

I.—The posterior tails of the bandage are brought forward to and held by the anterior tongues of the retentive buckle.

II.—The anterior tails of the bandage are carried backward to and held by the posterior tongues of the retentive buckle.

III.—The middle tails of the bandage are carried upward to and held by the middle tongues of the retentive buckle. The tails are gently and evenly made tense.

This retentive buckle has the following advantages:

1. It does not readily get out of place forward, backward, or laterally.

2. It holds the fractured jaw upward, by the posterior tails of the bandage; upward and backward, by the middle tails of the bandage; and backward and upward, by the anterior tails of the bandage—thus fulfilling three important practical indications.

3. The sub-mental splint can be pressed more or less firmly against the fragments of the lower jaw, by loosening or tightening any or all of the tails of the bandage.

I have used this retentive buckle in two cases of fracture of the lower jaw. Both patients were adults. One had a simple fracture, and the other had a compound comminuted fracture.

(*a.*) The retentive buckle remained on the head of the patient who had a simple fracture during the first two weeks without displacement; something which has not occurred to me in the use of any other appliance for a fractured jaw. In this case the result was excellent.

(*b.*) The retentive buckle could be readily removed from the head of the patient who had a compound fracture, for inspecting and dressing the injury. A sub-mental splint of wire-cloth was found very serviceable. In this case, the final result was better than could be expected.

(*c.*) I began the use of the retentive buckle in the case of a boy

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about fourteen years of age, who had a simple fracture of the lower jaw. The reduction was quite perfect. This patient went out of my hands after three days of treatment, and my apparatus, taken off, was sent back to me. Some time after I saw the patient; the fragments were united, having a displacement of one-quarter of an inch.

HOSPITAL RECORDS.

PRESBYTERIAN HOSPITAL, NEW YORK.

REPORTED BY ALBERTO LACAYO, M.D.

VALVULAR DISEASE OF THE HEART AND RENAL CIRRHOSIS—DEATH. SERVICE OF DR. WHEELOCK.

Dennis Newman, —Aet. 49,—Ireland,—Married,—Laborer.

Previous History.—Has always been a hard drinker. Was not particularly out of health until May, 1874, when he began to suffer from violent palpitation of the heart. Could not lie down on account of great dyspnœa. On making an unusual exertion he had a burning pain in the cardiac region, that extended around to lower end of left scapula. His feet and legs were much swollen.

On admission, May 13, he was found to be a large, strong and well-nourished man. The cardiac symptoms, dyspnœa, and oedema of the feet and legs were present. On examination a loud, blowing mitral obstructive murmur was heard.

Ord.

Inf. Digitalis, 3 ij. }
Tr. Ferri Chloridi, M. xx. } t. i. d.

He gives no history of rheumatism. The urine was scanty, high colored, of acid reaction and contained *no albumen.*

May 19.—Urine normal. Pain and tenderness in the lumbar region. Appetite good. Bowels regular. Œdema diminishing. Heart symptoms much improved. Stopped digitalis.

May 28.—Pain in back gone. No palpitation. Some nausea and vomiting.

May 31.—Great pain in pericardial region. Œdema again marked. Bowels costive. Given magn. sulph., which moved him freely and gave him some relief.

June 1.—Ord. pulv. jalap. co. two scruples, to be taken at once. Free purgation. Œdema diminished. From this date he improved rapidly, and when he left the hospital (June 21st), his bowels were regular, his appetite good, no œdema, no headache, and the heart working nicely. The urine was normal.

Jan. 29.—Re-admitted. Caught cold in December, coughed hard, and had dyspnœa. In about four weeks œdema commenced about the ankles and spread upwards.

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Present Condition.—Marked general anasarca. Great dyspnœa, aggravated by lying down. The countenance is of a dusky hue. The pulse is irregular. The heart is hypertrophied and a mitral regurgitant murmur is heard. Ordered inf. digitalis, M. xxx every four hours.

Jan. 30.—Seen by Dr. Wheelock, who ordered inf. digitalis in drachm doses every two hours until some effect was noticeable; then lengthen the intervals. Face livid, pulse quite irregular. Bowels confined. Given—

℞

Hydrarg. chl. mite, gr. x.
Pulv. jalap., gr. xx.

M.

Chart., No. iij. One every night.

Feb. 3.—Much improved. Very little œdema. Allowed to sit up in chair.

Feb. 5.—Urine examined. Trace of albumen. No casts. Sp. gr. 1.021.

Feb. 15.—Slight œdema of lower limbs. Improving.

Feb. 17.—Abdomen tympanitic and tender. Two calomel and jalap. powders, given yesterday, failed to act.

Ord.

℞ Resin podophyllin, gr. ss
Ext. colocynth, gr. iij
Pil. No. j. One at once.

Peculiar coppery color of skin. Conjunctiva clear.

Feb. 20.—Casts, few in number and of the hyaline variety, found in the urine, albumen 1-8 of bulk. Mild, rambling delirium at night. Ascites. Bowels moved freely several times.

Feb. 22.—Bowels kept open with compound jalap. powder (grs. 20, twice a day). Some dyspnœa. Abdomen enlarging. Given brandy, ℥ ij every two hours, and inf. digitalis ℥ i every four hours.

Feb. 26.—Nocturnal delirium more marked; abdomen slightly less tumid. Pulse 42, and irregular. Some dyspnœa. Considerable cough. Urine contained granular renal cells (a number.) Few hyaline and granular casts.

Sp. Gr. 1.024. *Color*, deep red. Reaction acid albumen 1-4 of bulk. Amt. 13 oz., 2 dr.

Coma vigila day and night. Double murmur at apex of heart.

Feb. 28.—Semi comatose. Refuses food. Epistaxis. Urine 9 oz. 3 dr. It contained some blood, oxalate of lime, and hyaline and waxy casts. Albumen 1-3 of bulk. Very little œdema. Bowels open.

March 1.—Urine 7 oz., 1 dr. High colored. Casts abundant. Albumen 1-2 of bulk. Will take no nourishment. Ord. inf. digitalis ℥ ss every 3 hours. Pulse 32 and irregular. Coma deepening. Delirious at night. Gets up and tears the bed-clothes to pieces. Insists on wandering about the ward.

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March 3.—Coma marked. Face dusky. Pulse, 30. Digitalis stopped. Brandy, ℥ ss every half hour.

March 4.—Died without struggle or outcry, at 1 A. M.

Autopsy 34 hours after death. *Thorax.*—Pericardium contained six ounces of a clear, yellowish-brown fluid. Heart. Both auricles much dilated. The left auricle hypertrophied. The mitral valve was incompetent and narrowed. Its edges were considerably thickened; other valves competent. Small vegetations on the bicuspid valve. Weight of heart, 18 1-2 oz.

Diameters of the various orifices as follows:

Aortic,	1 1-2	inches.
Pulmonary,	1 3-4	"
Mitral,	1 1-4	"
Tricuspid,	2	"

Lungs.—Right lung at the posterior surface of the apex was firmly adherent to chest wall. The pleura over the lower portion appeared like cicatricial tissue. There was partial consolidation of the lower lobe.

Left lung, bound down posteriorly near the apex. Hypostatic consolidation (?) throughout.

Abdomen.—The peritoneal cavity contained 74 oz. of a turbid, yellowish-brown fluid. The omentum of a slate color. Deeply congested. The intestines were firmly bound down in the right iliac region by cicatricial bands.

The *spleen* was congested.

The *liver* was small and cirrhotic. Weight 3 lbs. 7 oz. A few spots gave waxy reaction with iodine.

Kidneys slightly smaller than normal, of a deep red color. Capsule slightly adherent. Stellate veins well marked. Surface somewhat granular and markedly lobulated. The cortex diminished in size and gave a grating section. Pyramids distinct. Each renal pelvis was dilated and showed stellate veins. Ureters slightly dilated. Conjoined weight, 11 oz.

The supra-renal capsules together weighed 98 grains. The right weighed 46 grains, and contained many yellowish bodies, that looked like concretions. The medullary portion was brownish-black and not broken down. Microscopical examination showed an excess of fibrous tissue in both these bodies.

The left weighed 52 grains, and resembled the right in every way save that it was more deeply lobulated, and had a firmer cortex that was lighter in color than that of the right.

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CONGENITAL DEFECT OF THE LIMBS.

[London Med. *Record*, Feb. 15th, 1878.]

Dr. Weinlecher showed to the Imperial Royal Medical Society, of Vienna, a man aged 27, the subject of defective development of both upper and lower limbs. His right arm was represented by a stump, furnished with muscles, to which various artificial apparatus could be attached. In other respects the man was well formed; he had been married several years, and was the father of two children. In commenting on this case, Dr. W. said that many cases of this deformity were, according to prevailing views, to be attributed to arrest of development; but, in other cases, as had been shown by some authors, and he had himself observed the total or partial want of limbs was evidently due to extra uterine constriction by the umbilical cord, or by amniotic bands. N. M. S.

SAYRE'S TREATMENT OF SPINAL DISEASE.

[*British Med Jour.*, Feb. 9th, 1878.]

Dr. Bernard Roth, in a letter, states :—"The time for discussion on Mr. Berkeley Hill's interesting spinal cases, treated on Dr. Sayre's plan, was so limited that I had no opportunity of informing the members present that this so-called newly-introduced method of suspension by the gallows has been largely employed for many years past, in several orthopædic institutions on the continent, and that I saw last spring nearly the same apparatus used by Dr. Klopsch, Prof. of Surgery at Breslau, in Prussia. * * * * Complete suspension in the air is also employed very often. Even the shoulder loops are quite identical with those now said to have been invented by Dr. Sayre. I saw a similar apparatus and treatment at the orthopædic institution of Dr. Schildbach, Leipsic. * * * * It is a curious fact that, in Germany, the gallows is called 'Glisson's swing,' after Francis Glisson, an English physician, who wrote a book, '*De Rachitide*,' a second edition of which appeared in London in 1660. He gives at page 368 a description of the swing, with an illustration, and

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explains the principle on which it is used." Dr. Roth concludes:—"I have no wish to depreciate the great debt of gratitude we owe Dr. Sayre for the introduction of the plaster-of-Paris bandage for spinal disease, especially Pott's disease, but I do not think it is quite fair that no acknowledgment has been made of the real inventor of the suspender, or of the fact of its having been long in common use in Germany." N. M. S.

A SUCCESSFUL GASTROTOMY.

(*British Medical Journal*, March 2d, 1878.)

Dr. F. Trendelenburg reports in the *Wiener Med. Presse* another successful case of gastrotomy to be added to the hitherto unique case of Verneuil. A boy aged seven years, the subject of impassible stricture of the œsophagus from swallowing caustic potash, had fallen into extreme marasmus. Gastrotomy was performed without bad effects, and two days afterwards nourishment could be introduced into the stomach through the small resulting gastric fistula. A small drainage-tube of the thickness of the little finger was introduced into the fistula, into which was passed a thicker glass tube, having attached to it an elastic gum catheter reaching to the mouth. When the boy wants to eat, he chews his food and expels the masticated mass through the tube into the stomach. Four months after the operation, the boy's weight had increased by a fourth. E. J. B.

NEWS ITEMS AND NOTES.

The Telephone in Fever Hospitals.—A writer in the *British Medical Journal* makes the following suggestion:—That the instrument in question should be used for convalescent patients within fever-wards to converse with their friends, to whom immediate access is necessarily denied on account of infection. A telephone can easily be carried from bed to bed in a ward, and the corresponding instrument might be fixed at any office at a distance. In our opinion this is a good and humane idea.

Bogus Diplomas.—Robert D. McClure, of Philadelphia, convicted of forging a diploma of veterinary surgery, has been sentenced to nine month's imprisonment, and a fine of $200.

The University of Pennsylvania, Medical Department, has "received about $42,000 in fees from the students during the past five months; enough not only to pay all salaries and all the running expenses of the school, but also to fit up all the laboratories, and leave a small surplus over and above all expenses."

Galloping Consumption.—About two million pounds of horse flesh are annually consumed in Paris, and the demand is steadily on the increase.

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THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY.

A WEEKLY JOURNAL OF MEDICINE, SURGERY AND THE COLLATERAL SCIENCES.

EDITED BY

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EDITORIAL.

FRACTURE OF THE FEMUR.

Prof. Hamilton's recent lectures on Fractures of the Femur, delivered at Bellevue Hospital, have been extensively copied, and have brought to the front in defence of their own peculiar views a number of contestants. There is not, however, that degree of harmony in their doctrines and practice which is required to give them force. Each writer finds some fault with all other methods but his own. The reader may conclude, therefore, that the questions at issue are to be determined rather by the relative standing, general reputation and experience of the several writers, than by their simple assertions of the greater excellence of their peculiar methods.

In the *St. Louis Medical and Surgical Journal* for March, 1878, there

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appears an article entitled "Review on the Treatment of Fracture of the Femur," by Edward Borck, M.D., which is supplementary to an article from the same writer published in the January number of the same journal, and describing his mode of treatment. The two papers are characterized especially by their misquotations of other writers and by a certain flippancy of style.

In the January number Dr. Borck says (quoting as he subsequently explains from the *Journal of Materia Medica* for November, 1877), that Dr. Hamilton declares "there will always be some shortening in these fractures." Dr. Hamilton has never said anything of the kind, as every intelligent medical man knows who has read his writings or listened to his teachings. Dr. Borck in the second paper refers to Dr. Hamilton's "General Treatise on Surgery," and to his well-known "Treatise on Fractures and Dislocations," as if he had them before him when he wrote. Why did he not refer to these books for Dr. H.'s opinions rather than to the *Journal of Materia Medica.*

In the second paper Dr. Hamilton is quoted three times, the marks of quotation being employed in each instance. The language did not convey the impression that we were reading from Dr. H., and a reference to the lecture from which these quotations were made (*Medical Record*, January, 1878) showed that in neither was the quotation correct or nearly correct. We had supposed that every gentleman understood that in making a quotation from an author, and especially when the marks of quotation are employed, the writer is bound to use the words and punctuation of the author. Dr. Borck seems to think differently, and therefore exposes those whose opinions he handles to the risk of being so soiled before they are shown to the public that no one would recognize them, and the author himself would refuse to claim them.

Outside of the marks of quotation occurs the following passage: "Then he" (Dr. Hamilton) "passes, in review different modes of applying splints, and is particularly disgusted with the double inclined plane, charging it with shortening and with other faults. In this category he includes the lateral and coaptative splints. The Doctor tried these machines often in his early days, and uever had obtained a good result, except by mere accident. He seems to be exceedingly unfortunate in the treatment of fractured femurs, with the inclined plane and other apparatuses, while other surgeons, it seems, were very fortunate with these methods, and obtained what was called very good results."

The term "disgust" used by Dr. Borck to indicate Dr. Hamilton's opinion of double inclined planes, is original with Dr. B. Dr. Hamilton's real opinion will be better understood by reading the lecture referred to or by consulting his writings elsewhere.

If the phrase, "in this category he includes the lateral and coaptative splints" means anything, it must mean that Dr. Hamilton is disgusted also with coaptation and lateral splints. While the fact is, that in the lecture quoted from, and in all his published writings he has constantly urged the value of lateral or coaptation splints.

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The last clause of the paragraph now quoted from Dr. Borck, contains a flippant slur, which cannot be passed unnoticed, not so much because of its utterance by Dr. Borck, as because it is the repetition of an insinuation to which Dr. Hamilton's truthful representation of what has been accomplished by him in the treatment of fractures has subjected him to from others.

Whenever, of late, an American surgeon or mechanic patents a splint, and occasionally when the advocate of a particular mode of treating fractures has not patented his opinions, it has been found convenient. first, to state that Dr. Hamilton never makes a limb as long as it was before, or that he is "exceedingly unfortunate in the treatment of fractured femur;" and secondly, to affirm that the apparel now presented does make perfect limbs, neither of which statements are true. Thus a certain Dr. Parke, of Bloomington, Ill., whose useless splint is, we belive, patented, says:—"Prof. Hamilton says there is no splint yet devised that will prevent shortening of a fractured femur. I claim it is impossible for the limb to *shorten while in this splint.*"—(*Dr. Parke's Circular, p.* 2.)

At the 25th annual meeting of the American Medical Association, held at Detroit, June 2d, 1874, in the discussion which ensued upon Dr. Lewis A. Sayre's report on the subject of fractures, Dr. Sayre said, "that he *knew* his measurements were correct; that Dr. Frank H. Hamilton had made the measurements, and that he was a man who was so violently opposed to the theory that, in his published writings, he had denied the possibility of any oblique fracture being cured without shortening. For this reason he (Dr. Sayre) had asked him to measure the patients. He (Dr. Hamilton) said if seven successive cases would be presented he would agree to give up his opposition to the theory. He found the cases and surrendered."—*Detroit Review of Medicine and Pharmacy, July,* 1874, *p.* 360.

Dr. Hamilton was not present, and although the statement was generally discredited, no one was authorized to make a formal denial. However, in the succeeding number (Aug., 1874) of the same journal will be found a statement from Dr. H., in which he says that Dr. S. has "fallen into a slight error;" and that he does "not think he has seen two" treated by Dr. S. and not shortened. Dr. Sayre has never publicly made any correction of his statement. We are informed by Dr. Hamilton that there was not the slightest foundation for Dr. Sayre's statement, and that although he had seen one case in his wards, shown to him by the house surgeon, united without shortening, he had never seen any other case, nor did any such conversation, or admission ever take place. There was not a word of truth in the whole matter. As against this one case, Dr. Hamilton has published a number of cases occurring in both children and adults, treated by him and united without shortening (see 5th Ed. Fractures and Dislocations, p. 434), and he published at the same time a table, showing the comparative results of the plaster-of-Paris, and the American mode of extension adopted by himself; the results being greatly in favor of the latter.

This determination to misrepresent what surgeons have hitherto

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claimed that they were able to do, has been occasionally shown in a more general assault or insinuation, at the last meeting of the American Medical Association, held at Chicago, June, 1877. In the surgical section, on the first day of the meeting, two consecutive resolutions were passed, one of which was intended as a substitute for the other, both being to the effect, that shortening after fracture of the long bones was the rule rather than the exception. The subject was never referred to again either in the section or in the meeting of the society as a body. In the published proceedings of the society contained in the *Medical Record, June 23d*, 1877, appears the following paragraph: "Dr. Lewis A. Sayre, of New York, rose to a question of privilege, and entered his protest against the resolution adopted by the section on Tuesday, to the effect that shortening followed fracture, in spite of any method of treatment now in use. It was a confession that the profession could not treat a fracture, and he protested against any such declaration." This report was copied into some other journals from the *Record.*

The fact is, that no such protest was ever presented to the society by Dr. Sayre at the time stated or at any other time. It was found originally in one of the Chicago papers, and thence found its way into the *Medical Record;* and was undoubtedly written by Dr. Sayre, as he has never denied its authorship. How it reached the daily paper is not explained, nor is it material to know. The point of interest in this connection is, that the protest conveys *to the public*, as well as to those of the profession of medicine who were not present, the idea that the members of the American Medical Association admitted and claimed publicly that they could in no case make broken bones unite without shortening, and that they were by their own admission incompetent to treat a fracture.

This was said to a daily newspaper, and the public was told that Dr. Sayre had dared to say it to the 500 surgeons then assembled, including Drs. Gross, Hodgen, Smith, Hamilton, and many others, none of whom believed that perfect union could always be obtained. No one rose to reply—and for the reason that the protest was never offered, or read, or named. Dr. Sayre spoke upon other matters, but not one word upon this subject. We cannot feel surprised that a writer in the *St. Louis Medical and Surgical Journal for Nov.*, 1877, should have said: "The American Medical Association most justly rebuked Dr. Sayre, and he should have been thankful that the rebuke was couched in such mild terms, but, instead, he offered an insult to the Association and to every surgeon in the land."

It will be observed that those gentlemen who always make perfect limbs, (namely Drs. Parke, Borck and Sayre) do not use the same apparel. Dr. Sayre, a few years ago, used only the double or triple inclined plane, and claimed then, as now, that he always made the thighs of the same length. He now accomplishes the same result with plaster-of-Paris in the straight position. Dr. Parke uses a straight metallic splint and screw for extension, and gets perfect limbs. Dr. Borck puts the thigh in a flexed position and gets perfect limbs. The fact is that among the few,—and they can be counted upon the

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fingers,—who claim to always make perfect limbs, almost no two are agreed upon the same plan; but their methods are the most opposite and irreconcilable. They only agree in a habitual misrepresentation of the opinions of others, and in absurd claims as to what they themselves can do.

Dr. Borck gives a qualified approval of Dr. N. R. Smith's and Dr. John T. Hodgen's suspension splint, neither of whom we venture to affirm, would have approved of the much less sensible apparatus of Dr. Borck. Dr. Hodgens' apparel is excellent, and needs no endorsement from us or any one else; but when he presents his arguments and facts to prove its excellence, he never claims to make always, or even generally, perfect limbs, nor does he misrepresent the opinions and practice of others.

The *Louisville Medical News* of March 16, 1878, makes Dr. Hamilton's lectures, already referred to, the text of some editorial remarks and criticism. The writer prefers plaster-of-Paris in fractures of the thigh to all other modes of dressing; but he says in reply to the question put by himself, whether, under the plaster treatment, the thighs have shortened, "Probably they have, as a rule, a half inch or so." This is not what Dr. Sayre would claim from the same plan of treatment, nor what Drs. Borck or Parke would claim from very different plans. The writer intimates that probably Dr. Hamilton does not know how to use the plaster; but is it not proper to suggest; also, that inasmuch as the writer does not get as good results as Dr. Sayre does with the same apparel, that he also needs instruction?

The writer adds, "Prof. Hamilton says his colleagues have pretty well abandoned the plaster dressings. He may think so, but one must go away from home to learn the news. Does not Prof. Van Buren still believe in it; is it possible that Dr. Sayre has weakened in his faith concerning it, or is its stout defender, Dr. St. John, ready to retract what he has said about it. We imagine Prof. Hamilton has been misinformed." Dr. Hamilton is quite as liable to be misinformed as Drs. Cowling or Yandell, but he seldom repeats a statement made to him until it has been verified. In this particular case, however, Dr. Hamilton's opportunities of knowing the facts were such that he must have made the statement deliberately, knowing it to be true or false. Dr. St. John was never a visiting surgeon at Bellevue Hospital, but he was a very able and efficient house surgeon when completing his medical education. Dr. Sayre has not had a general surgical service in two years—only an orthopedic service, and Dr. Van Buren has not had a service of any kind at Bellevue in many years, probably 15 or 20.

Dr. Hamilton will, we are informed, soon give a full statement of the fractures of the thigh treated in that hospital during the year ending Jan. 1, 1878, from which it will appear that of 38 cases in the four surgical divisions, only one was treated wholly by plaster-of-Paris.

Dr. Louis Bauer also contributes a paper in the *St. Louis Clinical Record* for March, 1878, upon the "Treatment of Fractures of the Shaft of the Femur," which, like the two preceeding, is devoted to a review of Dr. Hamilton's late clinical lectures. Dr. Bauer commences

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by declaring that he has abandoned his original plan, "the wire breeches," having adopted of late the following conclusion, "on these and other grounds we are therefore compelled to reject the theory of muscular contraction as one of the causes of shortening in otherwise properly managed fractures, and with the theory vanishes the remedial panacea of extension." Dr. Bauer now uses a "metallic fracture box" made of sheet iron and fitted to the limb. The limb being placed in a flexed position, extension is never employed.

Dr. Bauer says he has used this in a number of cases and has "had good success. "Precisely what he would consider good success he does not inform us. He does not say that this method always makes perfect limbs, but leaves it rather to be inferred, since he says nothing to the contrary. Dr. Hamilton always states explicitly what he means by good success, why should not other gentlemen who differ from him as to the best mode of practice be equally explicit? Is it fair to science or to the gentleman who has so long stood as a bulwark between unjust prosecutions and his professional brethren, to make any concealment of his results, or, indeed, to omit in a single instance to state them fairly?

Dr. Bauer takes exception to the extension in Dr. Hodgen's apparatus. He thinks also that Dr. Hodgen's apparatus exposes to the danger of a false joint, owing to its great mobility. Finally, he quotes Dr. Gross, Erichsen, the late Dr. Nathan R. Smith, and Dr. Hodgen as "staunch advocates of the treatment on the double-inclined plane." If he will again look at the works of Drs. Gross and Erichsen he will see that he is mistaken as to their views. The authority of these names, he adds, "should have been a sufficient inducement to Prof. H. to try its merits, to which his connection, as a surgeon, with one of, if not the largest, hospital of the American continent gives him special opportunities for doing. We feel the more disappointed at the obvious disregard of a self-suggesting duty, since Prof. H. and his treatise on Fractures have rapidly acquired an expert authority with the profession of his country—admitted as such in courts of justice. Since Prof. H. has entirely disregarded the question of comparative value of the two methods, we may be permitted to discuss it with a view of eliciting the interest of the profession. The reason why the double-inclined plane has not been more generally used by surgeons is chiefly owing to the mechanical imperfections of most apparatus thus far known and employed."

We will again ask Dr. Bauer, who has had some experience of the unfairness of certain of his contemporaries in their discussion of his own contributions to surgical science, and who is too much of a gentleman to intend a misrepresentation, to read what Dr. Hamilton has written on the "comparative" value of the flexed and the straight position, and as to the experience he has had with both, referring him especially to his report on "Deformities after Fractures" made to the American Medical Association in 1857, and to the several editions of his "Treatise on Fractures and Dislocations."

Dr. Hamilton's views of the best treatment have been changed or modified from time to time, and in every successive edition he has

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carefully stated these modifications, so that one who has read the first edition will scarcely find a form of apparatus approved by him to-day or illustrated in the last or 5th edition, or the German edition, which was recommended in the first, and in most cases the apparatus has been simplified, and brought more within the reach of the general practitioner. He still adheres to the straight position as that to be preferred in most cases; and he still prefers, *generally*, not to use plaster-of-Paris in fractures of the thigh. In these respects his opinions have never changed.

If we have been led into a more prolonged review of the reviewers than was our intention, it was not because we desired to vindicate the views and practice of any one gentleman, but because it seemed necessary in the interest of good morals and good manners. The matters of which we complain are not private grievances, but public, and we have, for that reason alone, given a public rebuke.

LECTURES.

CLINICAL LECTURE.

Delivered at the College of Physicians and Surgeons, N. Y.,

BY

FRANCIS DELAFIELD, M.D.,

Adjunct Professor of Pathology and Practical Medicine.

(Reported for the Hospital Gazette.)

I. Chronic Bright's Disease with Atheromatous Arteries. II. Thoracic Aneurism. III. Mercurial Tremors.

CHRONIC BRIGHT'S DISEASE WITH ATHEROMATOUS ARTERIES.

The patient who now presents himself gives the following history: In 1876, while at work at his business, that of a galvanic battery maker, he was seized with an attack of loss of consciousness and paralysis. It was in summer time, and he had been working hard, and had been drinking a large quantity of water. He felt exhausted and thought that he had suffered from a sunstroke. For two or three days he suffered considerably from vomiting and purging. At this time he also felt that he had great loss of power on the left side of the body. He went to the hospital and remained there about two months, when he was sufficiently recovered, and went to work in Philadelphia. While there, about three months ago, he had another attack of a similar nature, falling down while at work. Besides the loss of power, he had some trouble with his speech, being able to express himself only with some difficulty. His power of speech, however, he regained in about a month or two and now does not feel this faculty so much impaired.

The history that he gives us is one of hemiplegia, and the question would be whether it depends on apoplexy or on the occlusion of one of the cerebral arteries. The case does not properly belong to this clinic, but rather to that of nervous diseases, so we will not discuss this point but turn our attention to other features in the case.

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Examining the radial artery we find it to be tortuous and atheromatous. The heart sounds are normal, except a slight roughening in the first sound. The urine has been found to contain albumen.

The history that we have elicited is not quite definite enough for us to determine whether the trouble is due to cerebral apoplexy or to an occlusion of one of the arteries, but the practical point, as far as we are concerned, is the condition of the kidneys.

The state of this man's kidneys is the condition from which he suffers the greatest danger. It is very important in all those cases in which we have a history of sudden loss of consciousness followed by hemiplegia, and where, in connection with it, we find the arteries calcareous and tortuous, to examine closely into the condition of the renal organs. We may be almost certain in such cases that the patient has chronic Bright's disease. In almost all cases, without exception, where this combination of atheromatous arteries and hemiplegia exists, you will find chronic Bright's disease.

In these cases you may or may not find albumen in the urine. The patient may go for months and months without the appearance of any albumen, and yet the chronic Bright's disease is progressing, and he runs all the dangers that arise from the disease. The absence of the albumen from the urine, then, even for a considerable period does not prove that Bright's disease does not exist. The form of the disease usually present in these cases is that known as the small or atrophied kidney. It is probably that condition that exists in the patient who now engages our attention.

The chief danger that these patients run is from the cerebral symptoms that are apt to appear in the course of chronic Bright's disease. He, at any time, may become drowsy and stupid and go into a coma, or may have convulsions. He may die in such an attack, or may emerge from this condition and go on again in a fair state of health.

This condition of the kidneys furnishes us the only indication for treatment. His paralysis is gradually getting better, and his speech is coming back, but the chronic kidney disease is still going on and may continue to get worse. He is now taking Turkish baths and wears flannel next to his skin. which will prove beneficial.

There is a certain advantage in keeping these patients on small doses of the bichloride of mercury. The old theory as regards the action of this remedy in such cases is, that the medicine has a tendency to cause the absorption of the new tissue produced in the kidney by inflammation. As for myself, I do not know of any grounds for such a belief. After once the kidney tissue is affected in such a manner we cannot bring it back to its original condition. Nevertheless, no matter what the theory of its action may be, the remedy seems to me in practice to do a great deal of good. We need give but very small doses, as little as 1-50 of a grain will be large enough. We do not wish to get the constitutional effects of the drug. This dose will be large enough where the treatment is to be continued for a length of time, but if I do not wish the patient

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to take it for a long period I give it in larger dose, from 1-20 up to 1-16 of a grain. To this man, I should recommend the treatment by bichloride of mercury.

THORACIC ANEURISM.

This man has been to the clinic twice before, and the first time I made the diagnosis of an intra-thoracic tumor, probably an aneurism. I placed him on the iodide of potassium, and on his coming back two weeks afterward, I found so much improvement that I was in doubt as regards the diagnosis. Still another period of two weeks has elapsed, and we will now see the condition he is in at the present time.

At his first visit the symptoms were pretty plain. There was pain in the thoracic region and well marked dullness both in front and behind. He informs us that the pain has not recurred since he has been under treatment. You will observe that the swelling of the veins on the exterior of the thorax has continued and is perhaps more marked now than it was at that time. The same condition is now beginning to be apparent on the left side, whereas, when he first came under our notice, it existed only on the right.

There was a difference in the percussion note on the two sides and we will now compare them. You will observe that as I percuss you distinguish dullness on the right side immediately under the clavicle. On the second rib it is also duller on the right side, but the tone given to the percussion note by the bone makes the dullness less distinct. In the second intercostal space it is duller, and likewise over the third rib. There is, then, obscure dullness over this area of the chest on the right side, extending to the sternum.

On the back, there is well marked dullness on the right side between the scapula and vertebral column.

This brings the physical signs back to what they were four weeks ago. Two weeks ago they had partly disappeared, but to-day they are again well marked. Our original opinion, then, is probably correct and the man has an aneurism which varies somewhat in size, being sometimes larger and sometimes smaller. It is probably an aneurism of the thoracic aorta extending across the vertebral column to the other side of the chest.

These thoracic aneurisms are often remarkable for the absence of symptoms due to pressure. The lungs are situated on either side of the aneurismal tumor, and the heart lies in front of it, thus entirely covering it. They may often reach a considerable size, but being thus covered by the thoracic organs, may give rise to no marked symptoms and escape the acutest observation.

Only last week I saw a case of this kind. In making the autopsy I discovered an aneurism of the thoracic aorta as large as my two fists, and yet during life it gave no signs or symptoms beyond bronchitis.

In this man, I should think, that the aneurism was situated over the vertebral column.

In these cases I usually employ the iodide of potassium, as in many

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cases it gives the patient great relief, and in some it is of absolute benefit in reducing the aneurism itself.

MERCURIAL TREMORS.

This patient comes to us suffering from a trembling of the muscles of the limbs. For the last ten or twelve years he has been engaged in the work of silvering the backs of looking-glasses. Ever since he has been employed at this labor, for at least four months out of the twelve he has suffered more or less from the same symptoms. The symptoms would come on after working for a time, and he would then be obliged to quit work. After being idle, he would regain his health and then proceed with his occupation, until a fresh attack compelled him to desist. Previous to the present attack he has had no symptoms but the tremulousness, but now complains also of pains in his head and sensations as of something going round and round. He has no pain anywhere else. His appetite is very poor. He says he has very little strength left. There is, indeed, considerable uncertainty in his muscular action, but as you see, when I endeavor to hold his leg out straight, and tell him to bend it, it takes him a little time to cause the muscles to contract, but when they contract they do so still with considerable force.

With this history the diagnosis is plain enough, and you have no hesitation in concluding that the patient is suffering from metallic poisoning, and the particular metal is mercury, as you well know that an amalgam of that metal is used for silvering the backs of looking-glasses.

The man has been working in mercury for a considerable length of time, and from the very first he was affected by it. He was able to work for some months, and then becoming affected he took rest and got rid of the poison. Lately, however, he is apparently getting worse.

His present condition is characteristic of a moderate case of mercurial poisoning. This tremulous condition of the muscles is a characteristic symptom of this disorder and in worse cases there is actual loss of power, and finally the muscles waste away and atrophy until they are extremely reduced in size and strength.

Some patients are greatly troubled with neuralgic pains in various parts of the body, the trunk, the limbs, and indeed almost anywhere. The cerebral symptoms may be much more marked than they are in this patient, though, as you have heard, he complains of some trouble in his head.

On inspection of the gums you observe that he has the characteristic blue line along the margin. Patients are more apt to have this blue line in lead poisoning, but in poisoning by many of the metals besides lead, you are apt to have it more or less marked.

The treatment of cases of this kind is much the same as is the treatment of lead poisoning. Indeed, they may be treated with advantage in the same way, though the poisons are of a different chemical nature.

The first essential thing in the successful management of these

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cases is to stop any further absorption of the poison. This is the most important requisite, but it is, perhaps, the most difficult of all to carry out. These men earn their living by working in these poisons and it is extremely difficult or impossible for them to do other kinds of work.

The drug most certain to be of benefit in eliminating the poison is dilute sulphuric acid, which may be given in twenty drop doses, three, four, or five times a day. In lead poisoning, iodide of potassium is useful, but the best treatment here is by sulphuric acid. Other acids, both mineral and vegetable are likewise advantageous. This patient has been taking acetic acid, and no doubt he has derived benefit therefrom.

In addition to this, the patient will be much benefitted by the systematic use of electricity. Especially, is this treatment beneficial to those patients who not only have tremors in the muscles, but actual loss of power with atrophy. It is surprising sometimes to see how much benefit some patients will derive from such a course of treatment. Sometimes patients will come to you who have suffered for a long period of time with tremors and paralysis of the muscles. Their muscles may be almost completely wasted away, and yet in this deplorable state they will often be very markedly benefitted and perhaps entirely cured by a persistent and systematic course of treatment by electricity.

This man is very quick to suffer from the effects of the poison, but at the same time he is also very quick to recover from them. I see no reason whatever why he should not get entirely well and remain well. If we could get him to leave off his occupation entirely he might not need any medicine at all. At any rate, if he could stop working in the mercury for a couple of years it would tend greatly to prolong his life.

ORIGINAL ARTICLES.

PREGNANCY AND DIABETES INSIPIDUS.

BY
H. H. KANE, M.D.

Mrs. B. Aet. 32, Ireland—Married—Housework—has always been a healthy woman. No venereal. I was engaged to attend her in her ninth confinement about Aug. 1st, Five weeks before I saw her she began to suffer with œdema of the feet and legs to such an extent that her shoes and stockings could not be worn. This lasted about three weeks, when suddenly without the use of any medicines, she began to pass large quantities of urine, and suffered greatly from thirst. To use her own words she "drank and passed every day a bucket full of water." The œdema of the legs and feet now rapidly and entirely disappeared. She began to lose her appetite, which had previously been very good; had frontal headache; saw specks and flashes of light before the eyes, and was, for the first time, troubled with morning nausea. She was greatly

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constipated, going a week at a time without any movement of the bowels. Aug. 8th,—Still suffering from distressing thirst, and passes large quantities of urine. Is troubled with a form of incontinence, the urine dribbling from her as she sits or moves about the room. No œdema. Some headache. The urine was as follows:—

Sp. gr. 1.004	*Color*—Of water.
Reaction. Alkaline,	*Odor*—None.
Amt. 24 *hr's*—Pail full (?).	*Sed.*—Whitish.

Microscopical Examination:

Few Crystals of the *ammonio-magnesian phosphate. Vaginal epithelium* (a little), *Epithelial débris* (considerable), *Vibriones* (quantity).

Chemical Examination:

Albumen (slight trace).

Thought best to defer treatment until after delivery.

Aug. 11th.—Child born after an easy labor. Diabetes continues.

Aug. 13th—Milk made its appearance in great quantity, and the diabetes and thirst entirely disappeared.

Aug. 14th.—Woman doing well.

Oct. 17th.—No return of diabetes.

HOSPITAL RECORDS.

COLORED HOME HOSPITAL. NEW YORK.

REPORTED BY F. HUBER, M.D., HOUSE SURGEON.

MALARIAL NEURALGIA, ETC.—SERVICE OF DR. WHITALL.

Jacob H.,—negro,—aet. 25. W. I.,—single,—laborer.

Admitted Nov. 5, 1877.

Family history good. Drinks gin and beer, but not to excess. Habits irregular. Denies venereal.

With the exception of tertian intermittent fever, which he had some ten years ago in the West Indies, he has always enjoyed fair health. Up to within ten days he was in excellent condition. He then began to complain of chilliness, pain in back and head, followed by fever and pain in the left arm. The febrile movement and pain in arm would (he says) commence at 12:30 P. M and end at 10:30 P. M., every other day, while on the intermediate days a paroxysm would occur at 8 A. M., and last until 12:30 P. M. This continued for a week. For the last few days the double tertian character has not manifested itself.

On admission.—Pt. is found to be well nourished. Complains of pain in the left axilla, and along the left arm. There is numbness of the fingers of the left hand. Examination reveals anæsthesia of the integument on the inner and posterior aspect of the left arm and forearm as far as the junction of the middle and lower third, and tenderness at the point near the inner condyle, where the ulnar nerve is most superficial.

The distal phalanges of the fingers of the left hand are flexed,

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while the proximal are extended. There is anæthesia of these parts. He cannot feel the pricking of a pin, nor can he pick it up if his eyes be closed. The parts to him are numb, and look very much on first sight as do those of a person numbed by cold.

Appetite good. Tongue clean. Bowels constipated. P. 70. R. 21. T. 99°.

Urine, amber; acid; 1.015; non-albuminous. Heart and lungs healthy.

Nov. 8, 1877.—Since admission a record of temperature has been kept in order to detect any exacerbation, but none having occurred he was ordered pulv. Clark daily. (Quiniæ Sulph. gr. 15,—Pulv. opii. gr. j,—Pulv capsici gr. vi.)

A. M.—P. 80. R. 20. T. 99½°.

P. M.—P. 80. R. 20. T. 100°.

Nov. 10, 1877.—Pain in arm not as intense. Sensation returning to fingers. Numbness gradually disappearing in all but fourth and fifth fingers.

Nov. 13, 1877.—Pains much less severe and only felt near the elbow. Can now pick up pin with eyes closed, Numbness in little finger still marked. Less in other fingers. Temp. A. M., normal; P. M., not above 100° since admission.

Nov. 19, 1877.—Numbness has nearly disappeared. Pain only occasionally present. Anæsthesia of parts supplied by nerve of Wrisburg, still present.

Dec. 1, 1877.—No numbness of fingers. Mobility of same regained. Area of anæsthesia diminishing. Ord. liq. potassæ arsenitis.

Dec. 8, 1877.—Had a well-marked paroxysm of intermittent fever.

Dec. 10, 1877.—Another attack to-day. Ord. pulv. Clark, to be given on the 12th inst.

Feb. 14, 1878.—Since last note patient has had no further trouble. Is perfectly well.

HÆMORRHAGIC DIATHESIS.—SERVICE DR. WHITALL.

Richard G. Loyd,—light mulatto. Born in C. H. Hosp., Nov. 8, 1877.

Mother well nourished and in good health. Very carefully examined, but no syphilitic lesion could be found. Nothing known of the father.

Labor progressed satisfactorily. No more blood than usual lost during the third stage. Upon cross-questioning mother stated that a sister of hers would bleed a great deal when cut, but no further evidence of hereditary tendency to hæmorrhage could be elicited.

Child, when born, weighed 10 lbs., and was apparently in good condition. P. 140; R. 40; T. 98½°. About ten hours after delivery a slight oozing from the remains of the umbilical cord occurred. The blood was evidently deficient in fibrin, as it would not coagulate. Upon the application of tannic acid and a compress the bleeding ceased, but began again several hours later. Dressing renewed.

The next morning (Nov. 9), as the bleeding began for the third

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time, a piece of lint saturated with Monsel's solution was wrapped about the cord and the hæmorrhage thus effectually controlled.

An examination of the body revealed a number of venous extravasations in the subcutaneous connective tissue of the left side of the thorax and over the shoulder joint. The child is very anæmic. Nurses well. Functions normal. Has neither vomited blood nor passed any per rectum. Ordered

Fl. ext. ergotæ, m. v.
Ferrum dialysat. m. ij. } every two hours.

P. 140. R. 80. T. 99½°.

Nov. 10, 1877.—Other extravasations have occurred on the back and thighs. A microscopic examination of the blood showed the red corpuscles more globular than usual. The cells became crenated more rapidly than in a normal specimen and "rouleaux" did not appear.

Nov. 11, 1877.—Several other subcutaneous hæmorrhages have occurred. Child still anæmic; otherwise well. Treatment continued.

Nov. 13, 1877.—The extravasations which appeared first are growing paler, and are apparently undergoing absorption. Some slight psoriasis of hands and feet.

Nov. 14, 1877.—A further extravasation on inner part of thigh. The others are fading. Slight sprue. Child nurses well, and its bowels are regular. Stump of cord not yet separated.

Nov. 16, 1877.—No further developments. Child nurses and sleeps well, and seems well in every respect. Cord stump attached by few shreds was cut away. No hæmorrhage.

Dec. 6, 1877.—Since last note child has been doing well. Navel well formed and natural. To-day, after a crying spell, the child's mouth was filled with liquid blood. No lesion was discoverable. Though anæmic, the child is plump and in good spirits. Ergot discontinued some time ago. Iron continued.

Jan. 4, 1878.—Slight hæmorrhage from mouth this A. M.

March 15, 1878.—Heard from a few days ago. No trouble since last date. Has not fallen away, but is apparently perfectly well.

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PERISCOPE.

COLLABORATORS.

Dermatology:
HENRY G. PIFFARD, M.D.
Diseases of the Nervous System:
EDWARD C. SEGUIN, M.D.
Diseases of Women and Children:
FRANK P. FOSTER, M.D.
General Surgery:
EDWARD J. BERMINGHAM, M.D.
Genito-Urinary Disease and Syphilis:
ROBERT W. TAYLOR, M.D.
Materia Medica and Therapeutics:
FREDERICK A. LYONS, M.D.
Ophthalmology and Otology:
SAMUEL B. ST. JOHN, M.D.
Orthopedic Surgery:
NEWTON M. SHAFFER, M.D.
Practical Medicine:
E. DARWIN HUDSON, JR., M.D.

TOBACCO-AMBLYOPIA.

Galezowski (*Le Mouvement Medical*) divides amblyopia into nicotinic, alcoholic, hysteric, glycosuric, and albuminuric, besides that from cerebral tumors. Of these, all but the first two have corroborative symptoms aside from the amblyopia. Nicotinic amblyopia is not well known and has been stoutly denied. G. says, he has no doubt, whatever, of its existence. In 1863, Sichel said before the French academy, that every one who smoked more than 20 centigr. of tobacco a day injured his sight. Hutchinson, in *Hospital Reports*, gives 23 cases. The nicotinic and alcoholic amblyopia resemble each other, but there are distinctions. The *binocular* amblyopia of tobacco is more like the alcoholic amblyopia than is the *monocular* variety. G. places much reliance on the state of the pupil, which in the alcoholic amblyopia is largely *dilated*, but in the nicotinic, strongly *contracted*. Late experiments on animals by M. William, show that the action of nicotine is myopic and comparable to that of eserine. In double nicotinic amblyopia, the sight for distance decreases so much that the patient believes himself growing rapidly myopic. This remains stationary for a time and then objects become blurred, sometimes tinged yellow. The eye becomes injected, and though the vision steadily decreases, the visual field remains good. The sensibility of the retina is so exaggerated that if colors be shown in rapid succession he fails to recognize them. Headache, vertigo, hallucinations, and feebleness of memory are generally concomitants. Special feebleness of sight at night is generally marked which serves to distinguish this from alcoholic amblyopia. The *monocular* amblyopia from tobacco causes an object to be partly covered by a dark spot (scotoma), just as in hemorrhage of the macula, but the ophthalmoscope shows no hemorrhage. The spot enlarges rapidly; the *visual field diminishes* and amaurosis soon sets it. Ophthalmoscopically, there is at first a little anemia of the papilla, then spasm of the retinal arteries followed by atrophy of vessels and serous infiltration around the vessels. As nicotine is found in the smoke of tobacco, those who inhale deeply are more liable to suffer. The prognosis is good, but total *atrophy* of the nerve *may* occur. Total abstinence—atropine, if myosis exists,

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and pot. bromide, if nervous symptoms are marked—are the chief factors in the therapeusis. S. B. St. J.

VERNEUIL ON THE PATHOGENESIS OF GENU VALGUM.

(*London, Md. Record*, Jan., 1878.)

In a paper recently read before the Société de Chirurge, in Paris, the author rejects the theories of muscular and ligamentous origin of genu valgum, which, he states, do not appear to be well founded. While admitting that there is still considerable obscurity about the question, he adopts the osseous theory, basing his conclusions upon personal observation. This is the view held by many distinguished authors, who only differ in assigning the deformity, some to hypertrophy of the internal condyle, others to atrophy of the external.

The author is disposed to accept the doctrine that the deformity is caused by hyperthrophy of the internal condyle of the femur, as put forward by Mr. M. Ollier and Tripie, who attribute genu valgum to abnormal activity of the epiphysary cartilage of the lower end of the femur. These authors, experimenting on animals, have been able to provoke, at will, hypertrophy of the internal condyle by exciting the internal half of the epiphysary cartilage, and of the external condyle by irritating the external half.

Although M. Verneuil has not had the opportunity of verifying clinically M. Ollier's theory regarding the two halves of the cartilage, he has, however, been able to observe some facts which confirm in a genuine way the principle upon which it is based.

N. M. S.

A BED FRAME FOR PREVENTING MOVEMENT OF THE BODY DURING THE EMPLOYMENT OF WEIGHT EXTENSION TO THE LOWER EXTREMITY.

BY

F. R. FISHER,

Surgeon to the National Orphopædic Hospital.

(The *Lancet*, Feb. 23, 1878.)

In the employment of extension to the lower extremity by means of the weight, cord and pulley, the effects of this force are often multiplied by the movements of the patient, especially if the subject under treatment is a child. By shifting the body to either side extension is no longer made in the straight line; by the patient getting down in bed the weight not uncommonly reposes quietly on the floor; by these and such like movements of the body an excellent method of treatment is much reduced in efficacy. To counteract these evils Mr. Fisher uses a simple and inexpensive appliance, and has found it answer very effectually the purpose intended.

The bed frame consists (a drawing accompanies the description in the *Lancet*), of two flat iron bars, bent somewhat in the shape of the

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letter U. The cross piece, corresponding to the curved portion, is joined to the lateral uprights by thumb screws, which allow these uprights to be approximated or separated, and thus to fit any patient, large or small. The cross bar is fastened with a strap to the head of the bed, under the pillows, and the lateral uprights have axilliary pads attached to them. This apparatus being fastened to the bed, and the trunk being secured by the axilliary straps, all movements of the body are prevented, and the restraint thus obtained is not of an irksome nature

Mr. Fisher concludes his article as follows: "Besides using this machine for hip joint disease, I have found it most useful in other cases where enforced recumbency is necessary, such as Poot's disease of the spine; for, in spite of the enlightenment recently afforded us on the treatment of this affection, I still adhere to the recumbent treatment in the early stage." N. M. S.

CORRESPONDENCE.

HOMŒOPATHY *VS.* TRUTH,

BY

THOMAS HERBERT ALLEN, M.D.

Visiting Physician to the Workhouse and Alms House Hospitals and Hospital for Incurables, B. I.

Did mortal ever behold a more miserable spectacle than that presented by the Homœopathic Medical Society of this country at its last meeting, March 11, 1878, when the question propounded was, "Shall we continue under the appellation 'Homœopathists,' or, in obedience to more modern teachings, and in the lurid light of allopathic (so termed) scientific advancement, *must we* renounce the delusive principle of our fathers, 'Similia similibus curantur?'" "We must obey the mandates of truth" was the decision by a vote of 18 to 17, and thus descends to the grave the last relic of this vicious system of practice.

The operation marking this transaction was not direct and noiseless, like the medicinal effect of Hahnemannic remedies; it was discursive and boisterous. To us, sons of the *Alma Mater*, whose kindly spirit and broad views have commended her to the thinking world, this recent meeting of the homœopathic fraternity has not passed unnoticed. We sympathize alike with that segment of it which is suspended betwixt Heaven and earth without a platform to stand upon; and with that which is content to pursue the beaten track through whose gloomy labyrinth the valley of death is finally reached. It is, indeed, a miserable picture to see men in this 19th century legally professing to be doctors so impenetrable to the light of science; happily this aspect applies only to a minority. But to that greater portion whose desire it is to cast off the shackles restricting them to the narrow rule, "similia," etc., we extend our congratulations.

We are not surprised either at the moans and groans of those more advanced in years, nor at the absence of logical reason which characterized their efforts to dissuade the enlightened; for men who accept

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undemonstrable affirmatives as facts, do not, after the lapse of time, like to believe that their practice has been but the execution of a lie. Such a dose is, indeed, an allopathic emetic. The action of the majority challenges our admiration.

No subsequent meeting, held after reflection has revealed the homœpathist's illegal position, can efface this record; it may change the letter of the resolution, but it cannot alter the spirit pervading its ranks. Now, to conclude, of what interest is this to the regular profession? None whatever, save that it glories in truth's vindication, and in the benefits which must thereby accrue suffering humanity.

March 11, '78, 147 W. 22d st.

ABOUT BOOKS.

Lessons in Laryngoscopy: including Rhinoscopy, etc. By Prosser James, M.D., M.R.C.P., etc. Second edition, illustrated with colored plates. London: Bailliere, Tindall & Cox. 1878.

The author states that in the present edition of this work he has not thought it necessary to revise the text, so that it stands exactly the same as in the first issue. The colored plates, however, at the end of the volume have been retouched and new ones added, and this portion is a very valuable feature of the work.

The volume claims to be practical in character, and, as the title indicates, is a series of lessons in the use of the laryngoscope and rhinoscope. A careful examination sustains the claim, and the work is undoubtedly a valuable aid to the beginner in this branch of study. The author has succeeded admirably in making the book clear and concise. His descriptions of instruments, and the method of their use are eminently full and thorough, though at the same time brief and condensed.

The principles involved in laryngoscopy are plainly stated, and the explanations are noticeable for their perspicuity. In this connection we may point out particularly his remarks in regard to the difference in the relative position of the parts of the larynx and the parts of the image in the mirror. This is a point that it is sometimes difficult for the learner to understand, he being usually under the impression that the image is inverted. This impression is very nicely corrected and explained, and the beginner will get a perfect clear and precise conception of the laws of reflection involved, by simply reading over these few pages. Other portions of the work show the same marks of simplicity and clearness.

The author devotes a few pages to the history of the subject, and treats it quite fairly. He claims to have used reflected light in the treatment of diseases of the throat in 1856, two years previous to the appearance of Czermak's first announcement in the *Wiener Medis. Wochenschrift* in 1858. His case did not appear, however, until the publication of his book on "Sore Throat" in 1859. He likewise acknowledges that he did not foresee the importance of his discovery. The author remarks, "It will be seen in the sequel that I put forward

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no claim to priority, though being, at that time, unaware of what others had accomplished, I may feel justified in accepting the credit that is usually accorded to originialty. Moreover, though anticipated by others in the use of reflected light for the purpose of diagnosis, it is not disputed that I was the first person to apply topical remedies by aid of the faucial mirror."

The colored plates at the end of the volume are excellent, and faithful portrayals of nature, and the author has evidently been at great pains to make them so.

The work will be found of inestimable value to students; and those who are farther advanced will no less find pleasure and profit in its careful perusal.

NEWS ITEMS AND NOTES.

Mortality in India, Occasioned by Wild Beasts.—In 1875, 20,805 persons were slaughtered in India by wild beasts; and in 1876, 19,273 perished from the same cause. During the same two years 101,635 cattle were killed by tigers, snakes and wild beasts generally. No effort is made to stop this frightful mortality beyond the offer of a small reward for killing wild animals. The *Scientific American* suggests that if British ingenuity cannot suggest a feasible project, that an adequate reward will speedily bring forth plans from this side of the Atlantic for the extermination of these wild beasts.

Heating a City by Steam.—The experiment of heating Lockport, N. Y., by steam has proved, it is claimed, highly successful. Three miles of pipe properly covered with non-conducting material laid under ground through some of the principal streets radiate from a central boiler house, and fifty different dwellings and other edifices, including one large public school building, have been thoroughly warmed all winter. Dwellings more than a mile distant from the steam generator are heated as readily as those next door. Steam meters are provided, so that each consumer pays for what he consumes. It is claimed that the system can be developed so as to furnish steam at fifty pounds pressure transmitted through twenty miles of pipe.

Remarkable Endurance.—The unprecedented feat of walking 2,000 miles in 1,000 hours, has lately been accomplished in Dublin, Ireland, by W. H. Smyth, the "American Postman."

A Dosimeter.—Dr. George Colmer, of Springfield, La., has taken out a patent on an instrument which he calls a "dosimeter," or dose measure. It is essentially a syringe graduated in drops, mixtures, etc.

Novel Suit for Damages.—A suit for damages was recently brought by a father against the hospital authorities in Limerick, Ireland, for the death of his son, who whilst under treatment in the fever hospital,

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got out of bed, and falling into a yard, was killed. The plaintiff alleged that it was the duty of the authorities to provide sufficient attendants for looking after the patients admitted, and by neglecting their duty they were responsible for his death. The judge held that the action was not maintainable, for otherwise an action would be at the suit of every pauper for every real or fancied grievance; as for example for having been supplied with insufficient food, or even for defective sanitary regulations.

A Leech Barometer.—The following is a simple way of making a "leech barometer." Take an eighth ounce phial, and put it in three gills of water and a healthy leech, changing the water in summer once a week, and in winter once a fortnight. If the weather is to be fine the leech lies motionless at the bottom of the glass, and coiled together in a spiral form; if rain may be expected, it will creep up to the top of its lodgings, and remain there until the weather is settled; if we are to have wind it will move through its habitation with amazing swiftness, and seldom goes to rest until a high wind begins; if a remarkable storm of thunder and rain is to succeed, the leech will remain for some days before almost continually out of water, and show great uneasiness in violent throes and convulsive-like movements. In frost, as in clear summer-like weather, the leech lies constantly at the bottom; and in snow, as in rainy weather, it moves to the very mouth of the phial. The top should be covered with a piece of muslin.—EDWIN S. CLOUTMAN in *Scientific American.*

Notice to Subscribers.—A large number of subscriptions expired with the issue for March 15th. Subscribers will oblige by promptly remitting amount of subscription for ensuing year.

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THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY.

A WEEKLY JOURNAL OF MEDICINE, SURGERY AND THE COLLATERAL SCIENCES.

EDITED BY

EDWARD J. BERMINGHAM, M.D., and FREDERICK A. LYONS, M.D.
H. H. KANE, M.D., Associate Editor.

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[The editors hold themselves in no way responsible for the views expressed by contributors.]

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EDITORIAL.

A FALSE ACCUSITION.

In this age nothing should surprise us; nor should we be so weak minded as to be shocked at anything that transpires around us. Notwithstanding the fact that there is a great deal of truth in the foregoing assertion, should we not be both astonished and horrified at the pitiable spectacle of a person, styling himself a "minister of the gospel," standing forth as the champion and earnest defender of the late noted abortionist, Madame Restell. It is a pity that she is not alive to know that she had at least one admirer in the clerical profession.

We would consider this person, Reverend Mr. McCarthy, and his remarks, as too contemptible to be noticed, and as carrying with them enough self-condemation to need no refutation, had he not in the course of his effusion attacked the whole medical profession, and had not an abstract of his shameless discourse appeared in the daily papers of this city, where it has been read by many, and in which it was brought to our notice.

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The medical profession needs no vindication from such scurrilous abuse from other quarters, but when such statements as the following are made public, emanating from one who might be supposed, from his sacred calling, to have some authority, they cannot be passed over without receiving their well-merited rebuke and highly deserved censure.

The *Reverend* (*sic.*) in the course of his eulogistic remarks, says :— "In my opinion in the manner in which she was entrapped she was more sinned against than sinning. The fraud and falsehood by which she was made amenable to a law that is *universally violated* by the medical profession of this city cannot be too strongly condemned." Again:—"It is not going too far to say that Mme. Restell was prosecuted for the supply of a medicine which a large number of medical practitioners provide for their patients, and among them family physicians of reputation and skill."

We repeat that the profession requires no vindication from such wholesale slander and downright falsehood. Everyone knows that the medical profession more than any other exerts itself to bring these crimes to light and hand the offenders over to justice. If the clerical profession would aid us more in exposing the enormities of the crime in its moral aspects while we are doing all in our power to show in plain colors the physical sufferings it entails, we should meet with more success in suppressing the abominable practice. Indeed, our reverend gentleman says :—"I am acquainted with one case in which a Christian minister, now in good standing, actually engaged a doctor for such a purpose, and subsequently defended his conduct on moral grounds before the trustees of his church."

If such a case be true, both individuals are sadly deficient of all morality, both are criminals of the worst type, but which is the greater villain or the baser hypocrite of the two, he who sets himself up as the teacher and guardian of morality, or he who only professes virtue for himself and does not attempt to point out its way to others? There may be some who call themselves physicians who would so far degrade themselves and sell their conscience as to produce abortion, but no respectable member of the profession would be guilty of the act, or would fail to bring to justice any one whom he knew to do it. Should we condemn the whole clerical profession because of the transgression of one member, as in the case cited by the person who throws this abuse at us? With equal justice is the medical profession condemned because of a few vile wretches, self-styled doctors, who live by the nefarious trade.

But even to argue the point any further would be simply absurd. This attempt at wholesale false deuunciation deserves to be treated with nothing but silent contempt and derision, and we should not have stooped so low as to notice it, had it not been for the sacred garb worn by the author, but which he has signally disgraced. This is not the first time that Mr. McCarthy has made himself ridiculous, but when he so fragrantly insults the profession by falsely accusing it of a heinous crime, it is time for him to be held up as a mark for contempt.

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LECTURES.

CLINICAL LECTURE ON CHRONIC ENLARGEMENT OF THE SPLEEN, AND A DISCUSSION OF THE OPERATION OF EXTIRPATION.

Delivered at Bellevue Hospital, New York,

BY

ALFRED L. LOOMIS, M.D.,

Professor of Pathology and Practice of Medicine in the Medical Department of the University of New York.

(Reported for THE HOSPITAL GAZETTE.)

GENTLEMEN—Let us by a few questions obtain this man's history. He tells us that he has been sick about three years with what he imagined was liver-complaint. Previous to that time he enjoyed good health. He first noticed a change in his color, which became of a yellowish hue. Although he has suffered more or less during the three years, he has been able to work until about a year ago. He has never been in the habit of using alcoholic stimulants to excess, though he has not been a total abstainer. At different times he has suffered with pain in the abdomen, more on the right side than on the left.

When he was 14 years old, that is about 48 years ago, he suffered from chills and fever, the attack lasting about six months. At that time he lived on 26th street, near 3d avenue, in which locality there was a great deal of malarial fever. From that time he never suffered with any form of malarial disease until about five years ago, when he had a second attack which lasted him several months.

He had inflammatory rheumatism when he was 19. At that time all his joints were swollen, red and tender. He had pain in the chest at the commencement of his rheumatic attack, after which his joints became affected one after another. The rheumatism lasted about three months. He has had touches of the malady since then, but has never had a severe attack.

During the last two years he has noticed swelling of the feet and legs from the knees down. He first noticed the swelling in the feet and ankles, and it gradually extended upward. His abdomen has been large for a year or more. He never has had swelling in the face to his knowledge. He came to the hospital because he was too weak and debilitated to work. He has never had cough, does not expectorate anything peculiar, and is not troubled with vomiting. He has entire loss of appetite.

His principal symptoms, then, are swelling of the feet and abdomen, and a peculiar tawny color of the skin. Now, from this history, what shall we look for? Perhaps, he may have, as he thinks, some disease of the liver. Cirrhosis might be suspected. He tells us,

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however, that he has not been a hard drinker. As he has had rheumatism, we might expect to find some form of heart disease. You know very well that the heart is apt to become affected in such cases. There is, however, no cough or dyspnœa, common attendants of heart disease. Although these symptoms might be absent if aortic disease only existed.

In malarial enlargement of the liver there might be pain and swelling of the feet. Some forms of disease of the kidney might also be the cause of the swelling of the feet. But are there any other conditions besides kidney, liver and heart diseases that would account for the œdema of his feet. There is another very important condition, viz.: anæmia, and if you observe, the patient bears marked evidence of such a state.

Let us now make a physical examination of the abdomen. As you look at his abdomen you cannot help noticing that it is very much enlarged, but the enlargement is not quite uniform. It is more prominent in some parts than in others and especially is this the case on the left side. Tympanitic distention of the intestines might occasion such irregularities in shape, but percussion will easily determine if this is present.

You notice on inspection that the veins on the surface are much enlarged. This, of course, is due to some obstruction in the portal circulation. Generally the obstruction to the portal circulation, which produces such a condition, is due to cirrhosis, but it might be due to some other hepatic disease, as cancer, etc.

The abdominal enlargement might be due to the effusion of fluid, the result of chronic peritonitis, but if this was the case the respiration would be chiefly thoracic, if not entirely so, which is not the case in the patient before us.

Having learned all we can from inspection we will now proceed to percussion. We find that the area of liver dullness exceeds its normal boundaries by about two inches. In the median line the area of flatness is about an inch and a half below its normal boundary.

On the left side flatness on percussion extends from the normal position of the spleen down to the crest of the ilium and the edge of the enlarged spleen may be distinctly felt and easily grasped with the hands. By means of percussion, then, we find that the liver and spleen are excessively enlarged, especially the latter organ. There is no fluid in the abdominal cavity. The legs pit on pressure, showing that there is considerable œdema.

On examining the heart we find it to be normal.

The surface of the body, generally, you observe, is not so deeply pigmented as the face.

The first question that arises is, does the enlarged liver exclude cirrhosis? You are aware that we always have some enlargement of the organ in the first stage of cirrhosis. When the disease has gone beyond the first stage we usually have contraction; there may, however, be enlargement of the organ in advanced cirrhosis when there is something more than cirrhosis present. We may have fatty degeneration in connection with it; then we will have the organ increase in size.

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Besides this increase in the size of the liver we have an enormous increase in the size of the spleen, and we must ask ourselves what will give rise to such a splenic enlargement. The changes produced by malarial poisoning would be quite sufficient to produce such a condition.

I have just come to the clinic to-day from a gentleman in whom an incision has been made into the spleen by a medical friend, and, as the case is an extremely interesting one, I will briefly narrate it to you. In the case to which I refer there was enlargement of the spleen, but no enlargement of the lymphatic glands. The number of the white globules in the blood was markedly increased. The enlargement of the spleen was not so great as in the case before us. I saw the patient for the first time about two months ago, and the diagnosis of leukæmia was at that time made.

The splenic enlargement was, however, somewhat peculiar. It seemed more globular in shape, and the enlargement seemed to be more in one direction than is ordinarily the case in chronic splenitis. The question was suggested, might some other condition be present? This could only be determined by waiting and carefully watching the case. The prominence in one part became more and more marked as the case progressed, and the bulging in one particular spot steadily increases. About three weeks ago an indistinct sense of fluctuation was perceived, and it was determined to explore the tumor. A hypodermic needle was introduced, but before the fluid was withdrawn the needle broke, and a portion of it was left in the tumor. No disturbance followed, however, and apparently no harm followed the accident.

In passing, let me remark, that in an examination of this kind never use the hypodermic needle for explorative purposes. I once had an uncomfortable experience with it; I left the needle in a pleural cavity. The trouble with hypodermic needles is that they are apt to be quite brittle. A little rust in the canal, which it is impossible to detect, weakens the instrument very much, and it is liable to snap with the slightest twist. When you endeavor to withdraw the needle you are likely to break it off and leave a portion inside. There is no danger in the operation, and you may just as well use a larger needle, say the size next to the smallest that usually comes with the aspirator.

Two or three days ago I was called to this case, and, at that time, a little fluid was drawn off almost clear, but slightly yellowish, and containing in the center a little turbid mass composed of white and red globules and fibrin. The red globules thus obtained were of a peculiar shape and not of their normal rounded form. They were elongated and somewhat irregular. This led us to the opinion that there was a cyst in the spleen, and to settle this question, as well as to give the patient the best chance of recovery, Dr. Schnetter, of this city, to-day made an incision into it.

During the course of the splenic enlargement there had been frequent attacks of local peritonitis, so that the peritoneal attachments between the abdominal walls and the tumor were firm, and there was little danger in cutting down. A rather peculiar circumstance was

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now noticed. After the incision was made the fluctuation was not nearly so appreciable as it had been previous to the incision. The incision was made sufficiently large to freely admit the index finger, and about a quart, or certainly a pint and a half of fluid was pressed out. This fluid was somewhat gelatinous in character. Its examination gave negative results.

When the finger was passed into the cavity it gave the feel as if there had been inflammation inside. There was some free coagulated fibrin present, and there was a roughness of the inner surface. It did not have that free, smooth feel which you would expect in the cavity of an ordinary cyst. It did not, however, lead one to the conclusion that an abscess existed.

After the fluid was removed the organ became diminished in size. The cavity was thoroughly washed out two or three times, and a drainage tube inserted. We now await further developments. I speak of this case not because I think we have a similar one in our present patient, but simply because it is a remarkable one, and this one reminded me of it.

Now, what are we to do with the one before us? Why would it not be better to take the spleen out altogether? Every one of this class of patients, when they have reached this stage of the disease, die. In spite of treatment the swelling in the lower extremities increases, and albumen appears in the urine. The oedema of the feet may be due, however, to the anæmic condition.

I say, gentlemen, that these cases are hopeless, as far as medical treatment goes. I speak on this point with some earnestness, for I lost one of the dearest and best friends I ever had, from this disease. Medicinal treatment could do him no good, for he certainly had the very best that I could give him, and he had the ablest medical advisers in New York and a neighboring city, where he lived. He faithfully obeyed every direction as to treatment, and I am sure that if I had proposed to take out the spleen he would have submitted.

I have thought that this method of treatment would be justifiable. Animals can get along without the spleen, for the experiment has been tried on them. How far its removal would affect human life, has not yet been determined, but the question has been determined often enough that all patients die with this slow, chronic splenitis.

The treatment usually advised is plenty of fresh air and good nourishing diet, with tonics. The patient will, however, gradually become more and more emaciated, though he may eat large quantities of good digestible food.

In the case before us there is no point of fluctuation in the spleen. If there were any such point we should be pretty sure to find it, as we can manipulate the organ so easily. It is advisable, in these cases, to keep the portal circulation unloaded by means of cathartics suitable for this purpose. Arsenic, iron, and ergotine may be employed in the treatment. Ergotine may be injected over the enlargement, and the latest treatment is to inject it directly into the organ itself. One physician in this city says that he has cured two cases by this method of treatment. This is a good case to test its utility. I have tried the

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procedure myself, but perhaps not often enough to settle the question.

It is a question in my mind if it would not be a good plan to establish suppuration in the organ. Make an incision, put in a drainage tube, and gradually drain it away. It seems to me to be justifiable to do anything that would offer a slight chance of recovery, because these cases, under the usual methods of treatment, have such a very bad prognosis.

To speak candidly, we do not know much about these diseases of the spleen, and until quite recently, even its physiology has been unknown, and it may be doubted if we yet thoroughly understand that. As regards its enlargement we do know that it is a fatal disease.

CLINICAL LECTURE ON A CASE OF PERICARDIAL EFFUSION.

Delivered in the University Hospital,

BY

WM. PEPPER, A.M., M.D.

Professor of Clinical Medicine in the University of Pennsylvania.

(Reported for THE HOSPITAL GAZETTE.)

T. B., a sailor, was admitted to the wards on February 8th, suffering from some cardiac disease. When first seen he had high fever, and his pulse and respirations were both unusually rapid; his intellect was at that time perfectly clear. He complained of occasional pain far down in the lower part of the right side. Careful examination showed slight impairment of resonance over this region. The respiratory murmur was feeble, and a few crackling râles were heard, but there was no pleuritic friction sound, no bronchial breathing, and no dullness upon percussion. The morning after he was admitted his temperature was 105°. It was very hard to locate the beat of the heart, which was high up, far out, and unusually weak. The area of cardiac dullness had increased out to the line of the nipple, and up to the second interspace. There was no friction sound. The area of cardiac dullness took the form of a triangle with its widest diameter below. The man did not complain of any pain in the region of the heart. The high temperature made me suspect some deep seated inflammatory trouble. With a morning temperature of 105° he had a pulse of 110, whereas, in the evening, when his temperature was about 103°, his pulse was 78. This was a most remarkable state of things.

I ordered the man veratrum viride in doses of gtt. iij. every three hours. I left word with the resident that this drug should be stopped the moment that nausea, vomiting or cold sweating appeared. In addition to the above the patient was given gr. x. of salicylic acid every two hours. He was fed well, kept quiet in bed, and blisters were applied over the seat of pain.

On the 10th the temperature ran suddenly up to 105 4-5° in the morning, and a pneumonia of the whole of the right upper lobe came

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on. Usually lobar pneumonia affects the lower lobe. It never attacks the upper lobe, except when attended with serious complications, such as phthisis, bilious or typhoid fever, or some grave organic disease. If it affects the whole lung it may spread from lower to upper lobes but this is rare, even in children.

With this unexpected change in affairs I became alarmed. The patient sank into a state of typhoidal prostration, and became fiercely delirious and very sleepless. It was impossible to secure quiet sleep. Dry crusts formed rapidly on the tongue; the pulse ran up to 132; the respirations increased, and the heart's action grew exceedingly feeble. Digitalis was substituted for veratrum viride as a cardiac tonic, and instead of the salicylic acid very large doses of quinia were given. Muriate of ammonia was administered as an expectorant. The amount of alcohol was increased.

On the 11th the temperature was 102 4-5°.

On the 12th it ranged from 103° to 104°. The man died on the evening of the 13th, his temperature running up to 103 4-5°, and his pulse to 160 per minute.

As soon as I heard of this unhappy result I began to reproach myself for two things: (1.) That I had given the veratrum viride so long; and, (2.) that I had not sooner placed the man upon large doses of quinia. The veratrum viride seemed to be serving an excellent purpose, and yet, as I say, I am sorry I gave it so long. Thinking the case to be one of rheumatic fever with pericarditis I gave salicylic acid. It would have been far better to have given quinia a day sooner.

I intend to examine before you the heart and lungs. The *right lung* was, as you see, in a very serious condition. There was a concealed diaphragmatic effusion—lymph in the cavity between the lung and diaphragm. Adhesions between the edge of the lung and the diaphragm prevented this effusion from showing itself. A plastic pleurisy had formed with great rapidity over the lower lobe, causing intense congestion and strong compression. The plastic pleurisy with adhesions existed evidently before the man came to the hospital, at least I should judge so from the signs presented upon his entrance. See what a perfect example this specimen affords you of the organization of false membrane! This same plastic pleurisy extends up the inside of the lung, and fastens the inside of the upper lobe of the right lung to the pericardium. The upper lobe is enormously heavy and distended. Upon incision you see that it is as solid as flesh. It is just passing into the stage of grey hepatization. It sinks in the water like a stone, and a purulent, blood-stained liquid oozes out of it. You see what a granular appearance the surface presents. The pneumonia has evidently followed the pleurisy as a secondary symptom.

The *left lung* is extremely congestive, but will float. It presents no appearance of tubercles, or of any organic disease.

The *pericardium* is, as you can see, intensely congested. Upon close examination I find it studded with small points of lymph. These little beads of lymph show evidences of recent pericarditis. About a half a pint of serum has been effused into the pericardial sac.

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The *right cavity of the heart* contains an enormous quantity of fibrinous chicken fat clots, which have become intertwined so closely with the trabeculæ that I cannot separate them from each other. These bands of fibrin extend into the pulmonary vein, and are moulded upon the leaflets of the valves, whitened and hard. These clots are clearly of antemortem formation. The right heart is greatly overdistended with these chicken fat clots. They fill up the right auricle entirely, and extend into the veins. As I remove these clots *en masse* I get a complete cast of the auricle. These clots are tough and white and cut like leather. They largely occlude the pulmonary vein and vena cava. You are, I suppose, beginning to see why the man died.

The *left side of the heart* is large and firmly contracted. This left heart presents very much to me the appearance of concentric hypertrophy. This appearance may, however, be due to the spasmodic contractions of the muscle upon an almost entirely empty ventricle. In this side of the heart also there is a certain small amount of tough fibrinous clots.

The *aortic valve* seems healthy, as does also the *mitral valve*, though it also is more or less obstructed by small ante mortem clots. The left ventricle is too large for normal, and its muscle is too hard. There must have been some hypertrophy.

Now it is very plain that this was not a case of simple cardiac hypertrophy, but that there was some underlying constitutional condition which gave rise to the various heart phenomena. The *kidneys* are a good deal congested, but normal in size. The pyramids are healthy, and the capsules normal. The cortex is, however, coarse-grained and pale. There has plainly been a certain amount of chronic catarrhal nephritis. I think the microscope will show the tubules filled with a quantity of desquamated epithelium. (Microscopical examination showed the tubules filled with epithelial cells.

You see that we have before us the elements of a very complicated case. I say that the original organic affection was catarrhal nephritis. (1) from the evident hypertrophy and valvular disease, and (2) by reason of the diseased condition of the kidneys, as revealed by the microscope.

In addition to the heart affection the man was suffering from concealed diaphragmatic effusion, plastic pleurisy and pneumonia of the upper lobe. From a survey of these grave complications it is at once plain that even had the heart clot not carried him off the hope of cure was desperately slim.

The first fall in the patient's temperature may have been due to the salicylic acid.

This accident, namely, the formation of antemortem clots, should always be borne in mind. It usually occurs where there is hyperinosis joined with such great congestion and obstruction of the lungs that the right cavities of the heart cannot empty themselves freely. Heart clots may therefore form frequently in severe attacks of pneumonia. Heart clot has been the chief factor in this case.

The only means in our power of combating such a condition as the above, viz.: the formation of heart clot—is absolute rest in bed, and

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the reduction or limitation of inflammatory action by means of antiphlogistics. We certainly cannot directly remove the obstruction to the circulation, or prevent the rapid formation of fibrin.

ORIGINAL ARTICLES.

CASE OF OVARIAN TUMOR TREATED BY ELECTRICITY*

BY

G. A. PIERCE, M.D., NEW LEBANON, N. Y.

Reported by
A. VAN DERVEER, ALBANY, N. Y.
Permanent Member of the New York State Medical Society.

August 15th, 1877, Dr. Pierce brought to my office for consultation, Miss H., aet. 34, with the following history:

Family record good. No cases of tumors, &c., known among her ancestors. She has usually enjoyed good health, and, being a farmer's daughter, had worked hard the most of her life.

She began menstruating at about the age of fifteen years and her periods were always regular and continued so. She has experienced no serious illness at any time within her recollection. She now presents a sallow look, is much emaciated, abdomen very large and it is with difficulty that she can breathe and move around. About the umbilicus she measures 41 1-2 inches, and from the latter point to the anterior superior spinous process of the right ilium, 12 inches, and to that of the left, 11 inches. There is no œdema of the lower extremities, nor is there any indication of general anasarca. Action of the heart, natural; urine normal; respiration also normal. It is impossible to map out the boundaries of the liver. The measurement of the uterine cavity is 2 1-2 inches. There is fulness and fluctuation in the cul-de-sac of Douglas, and a general dullness exists over the entire abdomen nearly up to the ensiform cartilage, and fluctuation is very distinct. Dullness on percussion is very decided also in the lumbar region. Turning the patient upon either side apparently causes no floating of the intestines.

She stated that while menstruating about Sept. 1st, 1875, she took cold, and soon after noticed an enlargement over the region of the right ovary, which gradually increased in size. She came under the treatment of Dr. Pierce, June 2d, 1877, at which time the measurement about the abdomen was 37 1-2 inches.

On the 20th of July she was tapped and about 23 pounds of fluid obtained, the measurement about the abdomen being reduced to 27 inches. Aug. 27th, '77, about 8 ounces of fluid were obtained and examined both chemically and microscopically, with the following result: Neutral; sp. gr., 1.020; albumen, well shown. The microscopic examination revealed the presence of ovarian corpuscles

* Read before the State Medical Society, 1878.

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and crystals of cholesterine. The sac filled again to its original dimensions in about six weeks.

At the time of the consultation, I advised the doctor to make use of the galvanic current, introducing one of Kidder's insulated needles attached to the negative pole, directly into the sac, and applying the positive pole, by use of the sponge, over the surface of the abdomen, employing on an average about sixteen cells. The applications I advised to be made as often as once or twice a week, and each application to continue through a period of from fifteen to twenty minutes, as I had seen them thus made in a somewhat similar case by Dr. Wheeler of Chelsea, Mass. At the same time I spoke of Dr. Cutter's method of using his large needles with his cautery battery in the treatment of uterine fibroids, and expressed the belief that great good was to come from it.

By some strange error a Cutter's cautery battery with his large needles was sent on to Dr. Pierce by Codman & Shurtleff of Boston. The use of the battery was commenced Sept. 3d, electricity being applied at intervals of from four to seven days. She was persuaded to have the needles used the first time without the administration of an anesthetic, the pain was so intense, however, that chloroform was employed each time thereafter. The needles were introduced seven times and with a marked diminution in the amount of fluid after each introduction. Electricity was applied for the last time on Nov. 6th. Each application had varied in duration from ten to twenty minutes. After the last application, no presence of fluid could be detected. Her general health at this time (Nov. 6,) is very much improved, and there is, as yet, no sign of filling.

Dec. 2d.—The patient was again brought to my office. No fluid could be detected. The points of insertion of the needles appeared, and the tissue is considerably indurated. The liver is normal. The patient, however, feels very week, although her appetite is good and functions normally performed.

March 4th.—She is gaining in strength. There is no filling of the abdomen. There is, however, decided tenderness on pressure upon the right side over what seems to be the remains of the sac.

I believe this to be the first case of ovarian cyst ever treated by means of the large Cutter needles and cautery battery. While the treatment is one to which I should not care to subject another patient, and one which I certainly would not recommend, yet it seems to me to demonstrate the fact that a much stronger current of electricity can be borne by the patient in the treatment of ovarian tumors than has hitherto been believed. The remains of what is supposed to be the sac feels wrinkled or corrugated, a condition which Dr. Wheeler informs me he has noticed in his treatment of ovarian cysts by the milder galvanic current.

March 22.—'78, Dr. Pierce writes me that Miss H. is regular as regards time and amount in her menstrual periods. No enlargement of abdomen, but suffers greatly from indigestion and an inactive state of the liver.

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HOSPITAL RECORDS.

PRESBYTERIAN HOSPITAL, NEW YORK.

Reported by ALBERTO LACAYO, M.D.

MORBUS BRIGHTII—APOPLEXY—HEMIPLEGIA, AND DEATH.

Wm. B. Warren,—M.,—Aet. 39,—Compositor,—Admitted April 1, 1875.

Has been a compositor for sixteen years. Four years ago he first noticed an increase in the amount of his urine. At the same time it became almost colorless. Soon after this he had frequent calls to make water, passing considerable each time. In the last year he has also been obliged to rise six or eight times each night and urinate. Thinks that some days he passed a gallon of water. With this increase in the amount of urine he commenced to have severe and almost continuous frontal headache. Was also troubled with epistaxis, morning nausea and vomiting. Sickness and vomiting more marked in the last year, especially on brushing the teeth in the morning. In the past eighteen months his sight has failed him somewhat. Has had considerable pain in the small of the back. Never any œdema. Tendency to constipation. For past two years has a cough (worse at night), with muco-purulent expectoration. Gives a family history of phthisis.

For two or three days preceding March 17, 1875, had intense pain in the occiput. Head felt dull and heavy, and he had some epistaxis. Had not been drinking. Says he never drank. Feeling warm on that day he took a drink of cold water and poured what remained in the glass over his head.

He immediately felt dizzy, staggered and would have fallen had it not been for a post near by and the aid of friends. He was conscious for 24 hours, but at the end of that time became unconscious, and remained in that condition for two days. On arousing from this condition he found his entire side paralyzed and devoid of sensation.

Present Condition.—Complete left hemiplegia. No aphasia, but the speech is thick and indistinct. Head turned to the left side and nearly rigid in that position. Much emaciated. Tongue brown and dry. Pulse 120, full and soft. Is conscious and rational. Ord. spts, vin. gall, ℥ ss, t. i. d.

April 2, 1875.—Has involuntary evacuations of fæces. Quite childish. Cries for food at all hours.

April 4, 1875.—Speech somewhat clearer and mind brighter. Brandy ℥ ss, every 3 hours.

April 6, 1875.—In low typhoid condition. Speech indistinct. Less muttering delirium than last night. Brandy ℥ ss, every two hours last night, and every four hours to-day. Tongue heavily coated and of a

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dark brown color. Sordes on teeth and lips. Urine was as follows:

Sp. gr. 1.010.	*Color*—pale straw.
Reac. alkaline	*Odor*—ammoniacal.
	Sed.—slight.

MICROSCOPICAL EXAMINATION.

Large, small and medium-sized dark *granular casts*, and large and small *hyaline casts* (quantity.) Granular and atrophied renal epithelium (considerable.)

CHEMICAL ANALYSIS.

Albumen (a trace.) *H. H. Kane.*

Small mucus rales in left lung. Temp. 102.5°

April 7, 1875.—Somewhat improved.

April 9, 1875.—About the same. Tongue somewhat cleaner. Ord. potass. iodid. grs. v. every 3 hours.

April 21, 1875.—Slowly improving. Eats some solid food.

April 30, 1875.—About the same. Urine the same.

May 1, 1875.—Pleurisy of right side. Weaker.

May 16, 1875.—Slowly failing. Left side œdematous. Temperature of non-paralyzed arm (surface thermometer), 95 1-10°; of paralyzed arm, 97 5-10°.

May 21, 1875.—Some pneumonia; left side.

May 28, 1875.—Pericardial murmur. Effusion in right pleura. Lungs œdematous. Suddenly lost consciousness at 10 A. M., and breathed stertorously until 5 P. M., when he died.

AUTOPSY.

Body greatly emaciated. Rigor mortis, but slightly marked. Skin of yellow, cachectic hue. Left arm and leg much enlarged by œdema.

Thorax.

Right lung much compressed by fluid in the pleural cavity, there being 62 oz. of a turbid brownish yellow fluid present. It was bound down throughout by old and new bands of organized lymph. The upper lobe was pigmented, contracted and contained no air. Lower lobe firmly encased in a very thick pleural plastic exudation. The greater part of this lobe was pigmented and partook of pneumonic consolidation.

Left lung.—No fluid in pleural cavity. Lung œdematous and containing but little air.

Heart—Plastic lymph in fine fibrillæ interlacing on cardiac and opposing surface of pericardium. No effusion into pericardium. Heart very firm and evidently hypertrophied. Not opened.

Abdomen.

Spleen—Small, pale, and weighed 2½ oz.

Liver—Deeply pigmented. Congested. Weight, 2½ lbs.

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Kidneys—Small, pale, granular and containing small surface cysts, cortex thinned. Vessels thickened, enlarged and gaping on section. Some much dilated vessels in pyramidal portion. Capsule thickened and moderately adherent. Weight of left, 3¼ oz.; right, 3⅛ oz.

Supra-Renal Capsules.—Size normal. Cortex well defined and of brownish-yellow color. Medullary portion white and quite thick. The right contained some tubercular matter.

The *Peritoneal Cavity* contained 16 oz. of a dark-brownish fluid containing flocculi, and mixed with fæces, varying from a light yellow to a blackish-brown color.

The *stomach* was dilated, congested and in places ecchymotic. The walls were ruptured at two points, but whether ante or postmortem it was impossible to say. They were so thin as to allow the finger to be thrust through them easily. Small intestines congested.

Head.

The left lateral ventricle of the brain contained a recent clot, about the size of an infant's closed fist.

The right lateral ventricle contained an old yellowish-white clot, about 3 inches in length, and of about the thickness of a lead pencil. It also contained about 3 oz. of a yellowish fluid.

[This case, the history of which has been given rather fully, is one of unusual interest, and, though imperfect in many of its details, is, in a certain sense, a typical one. Specimens of urine for examination could only be obtained twice, and then it was necessary to use the catheter, the patient passing his urine involuntarily and not tolerating the presence of any form of urinal. It is to be regretted that the heart was not opened.

Some points of especial interest are the following :—

1*st.* Had the nature of the man's work (compositor) any hand in causing the renal trouble, as from chronic lead poisoning? His friends say that he neither drank nor used tobacco.

2*d.* Was the renal disease a separate affection or only a fragment of a general fibrosis?

3*d.* The age of the patient was quite early for death from this form of renal disease.

4*th.* The early appearance of morning nausea, vomiting, weak eyesight, headache, and excessive flow of urine.

5*th.* The amount and importance of the renal derivative found in the urine, with the small amount of albumen.

6*th.* The absence of œdema of any part of the body until after the apoplexy, and its limitation to the paralyzed side. Further, the difference in temperature between the paralyzed and non-paralyzed side.

7*th.* The amount of disease of the body generally, and death from a second apoplexy.

8*th.* The absence of all symptoms of acute uraemic poisoning.

9*th.* The complete manner in which liability in this disease to inflammations of serous membranes, and the tendency of the diseased vessels to rupture (especially in the eye and brain), is here exemplified.

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10*th*. The condition of the stomach; changes analagous to those in the kidneys having probably occurred here, as is often the case in this and other forms of renal disease.

It is doubtful if there is anywhere on record a fuller, clearer, and more typical case of "granular contracting kidney" where the symptoms, and pathological sequences in other organs, are so distinctly characteristic and readily traced as here. H. H. K.]

PERISCOPE.

COLLABORATORS.

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EDWARD C. SEGUIN, M.D.
Diseases of Women and Children:
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Orthopedic Surgery:
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Practical Medicine:
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REASON VS. TRADITION IN THE TREATMENT OF CERTAIN INJURIES TO THE WRIST JOINT.

BY

L. S. PILCHER, M.D.

(Proceedings Med. Soc. Kings Co., March, 1878).

Colles fracture is caused by the action of the anterior ligaments, the fragment being torn off. It partakes more of the character of a sprain than of a fracture, and when reduced by proper manipulation requires no splints to keep the fragments in place; indeed, the splints are hurtful. Massage, pressure and motion are required after the first few days. This is an original paper, and except that some of the authors views are a little too exclusive, it is sound. Probably nothing has been contributed which throws so much light upon this obscure subject since Vollmier and Robert Smith wrote.

DISLOCATION OF THE FEMUR UPON THE PUBES SUCCESSFULLY REDUCED AFTER 26 DAYS.

BY

M. H. HENRY, M.D.

(Am. Jour. Med. Sciences, Jan. 1878).

The first attempt made Oct. 23, was unsuccessful. The second attempt was made Oct. 29th. After repeated trials, by forced abduction and circumduction the head of the bone was thrown into the thyroid foramen, after which by abduction and extrusion it was conveyed into the acetabulum. He was dismissed cured in about three months.

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CASE OF OSTEO-SARCOMA OF TIBIA, RECURRING IN STUMP OF THIGH, AND PROBABLY AFFECTING THE LUNG.

BY

JOHN EWENS, L. R. C. P.,

(*British Medical Journal*, February 9, 1878.)

A boy, aged 8, was admitted into the hospital for sick children, Bristol, in May, 1876, with a large tumor of the upper extremity of the left tibia. The history given was that, some weeks before, he had been struck by a stone flung by another boy, and that he had walked some distance in the snow, and got chilled. The very rapid growth and general appearance of the tumor led to the diagnosis of malignant disease, and nothing but prompt amputation far beyond the limits of disease could afford the least chance of saving life. The inguinal glands, though more distinct than usual on account of the extreme emaciation, did not appear to be diseased. There was no abdominal tenderness, or evidence of any visceral disease. Amputation was performed by the circular method about the middle of the thigh. The wound was dressed with carbolized oil, and the arteries tied with carbolized catgut. Rapid union of the deep structures occurred by first intention; the patient was discharged, quite well, in about a month. The whole of the upper third of the tibia was involved in the malignant growth, which also extended into the joint (but did not invade the femur), and for a considerable distance down the cancellous tissue of the bone. The soft parts were also extensively involved. Unfortunately, the hospital cards containing detailed notes as to circumfence of the tumor, etc., have been lost or mislaid.

On October 14, the boy returned with a tumor, of the size of a small orange, on the inner and anterior side of the stump, which, he said, had been growing about six weeks. It was not very painful, and was somewhat movable, and probably had deep attachments. He said it had commenced on the surface. The inguinal glands were not tender or materially enlarged. His general health was wretched—hurried respiration, quick pulse—leading me to suspect extensive disease of the lung. On examination, dullness with extensive crepitation over the whole of the posterior aspect of the chest was detected. The only question remaining was the propriety of removal of the stump at the hip joint; but this was negatived after further careful examination of the amputated limb (which is now preserved in the museum of our medical school), the femur being found free from disease; and the inference was that, as the whole of the diseased structures had been removed, the malignant cachexia was so decided as not only to reproduce the disease in the stump, but most probably the lung affection was of a cancerous nature. He was therefore discharged, and lived about a month. I visited him about a week before his death, and found that the tumor had rapidly increased in size, and appeared as though it would soon ulcerate; but this did not occur, and the chest disease was the immediate cause of death. As he lives ten miles from Bristol, no post-mortem examination could be obtained.

E. J. B.

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DIVISION OF THE TENDO-ACHILLIS IN FRACTURE OF THE LOWER END OF THE FEMUR.

BY

M. A. MORRIS, M.D.

(Boston Med. and Surg. Jour., Nov., 1877).

Following the suggestion of Mr. Bryant, Dr. M. cut the tendo-Achillis in a case where the upper end of the lower fragment projected backwards, and was then able to employ extrusion and to obtain a good result.

ABOUT BOOKS.

F. H. Hamilton, M.D., LL.D. Knochenbruche und Verrenkungen,—von Dr. A. Rose. Gottingen, Vandenboeck and Ruprecht's Verlag, 1876.

Prof. Hamilton's well known and most valuable treatise on "Fractures and Dislocations," as may be seen by the above heading, has been translated into German by Dr. Rose. The work has now been before the English speaking part of our profession for a number of years and has passed through several editions. The favor with which it has been received has been universal, and it must be a source of great gratification to the distinguished author to see his book among the exceedingly few American works which have been deemed worthy of being translated.

With such marked approval has the treatise been accepted, that it is considered by every one as the classical work on the subject, and scarcely a question, in which a fracture or dislocation is involved, can now come up before a court of justice in which it is not referred to as the standard of authority by judge, counsel and experts. We have not the slightest doubt but that it will meet with the same marks of approval in Germany as it has already received in Great Britain and this country. It is not too much to say that as a monument of patient industry, careful research, original investigation, clear and able reasoning, *unbiased criticism and a just appreciation of the labors of others* the work stands without a rival. Indeed, the profession cannot estimate too highly the services rendered to them in the most uncomfortable and annoying situations in which a surgeon can be placed, by the conclusions reached and plainly set forth in Professor Hamilton's work.

Within a recent period it has been attempted to invalidate some of the author's conclusions, we refer especially to his statement as regards shortening of the limb after fracture of the femur, but after a careful review of the whole discussion it must strike every candid reader that his position has been unassailable and entirely unshaken. Fair and impartial criticism cannot fail to refute the arguments, or rather pseudo-arguments, that have been brought against it.

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Diseases of the Nasal Cavity and the Vault of the Pharynx, Translated from the German of Dr. Carl Michel, of Cologne on the Rhine, with an introduction by E. L. Shurley, M.D., and C. C. Yemans, M.D., of Detroit, Mich. C Young, Detroit, Mich., 1877.

This work is a quite complete monograph on the subject of which it treats and as such it is welcome, or rather it would be so if the translation were well done. This, however, we cannot say, for though it may be near enough to the original to make it correct, yet the construction of the sentences is entirely un-English.

The chief feature of the book, is the description of the method of removing polypi by means of the galvano-cautery instead of by the forceps, as is usually done. On this subject the author takes particular pains to dilate, and indeed in the treatment of many of the diseases he describes he uses this instrument quite freely, claiming greater success than with other methods.

NEWS ITEMS AND NOTES.

Horse Flesh as Food.—A depot is about to be opened in London for the sale of horse flesh as food..

A New Living Double Monster.—Heschl furnishes the description of an examination he has made at Vienna, of a living girl seventeen years of age, who exhibits an example of a still rarer form of monstrosity than the Siamese twins, or the Two-headed Nightingale, inasmuch as in her case the formation, in place of the upper part of the body being double, as in their cases, consists in a doubling of it only below the second lumbar vertebra, the upper portion resembling that of a pleasing, delicate girl of from ten to twelve years of age. The case is a specimen of Forster's *Dipygus tetrapus*—*The Doctor*.

Death of the Discoverer of Fœtal Auscultation.—The Count de Kergaredec, the first to apply auscultation to the detection of the fœtal heart in pregnancy, died lately in Paris at an advanced age. His son in announcing his death to the French Academy said: "Among his children who stood around his death-bed was that beloved daughter, the beating of whose heart her father heard whilst she was still in her mother's womb."—*The Doctor*.

A New Journal, known as *New Medicines*, has been started in Atlanta, Ga., and is intended as a means of communication between the medical and pharmaceutical professions in the South. It is a monthly, of 25 pages, at $1.00 per year, and is edited by Drs. Ferdinand King and L. G. Alexander.

Compensation of Medical Experts.—The Supreme Court of Indiana rendered a decision last month (February) of immeasurable importance, not only to the medical profession, but to the members of the other professions and callings. It was a test case, and is the first decision ever rendered on the subject by any court in this

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country, and, as far as we know, in any other country, and will be hailed all over the land as just and right. The particulars of the suit are briefly these: Dr. T. J. Dills and A. B. Buchman of Fort Wayne, Indiana, practicing physicians of reputation, were summoned by the defendant to give testimony, as experts, in a case of rape, State vs. Hamilton. They had no concern or interest in the case or man, and they refused to give the evidence unless they were properly compensated. The judge promptly ordered them to jail, and after they had exhausted every means to sustain the stand they had taken, they were forced to succumb and give the testimony, which they did under protest, and then they brought suit against the state. A decision was given in the lower court adverse to Drs. Dill and Buchman, but the Supreme Court of the State reversed the decision of the lower court and sustained the position taken by these physicians. The court "held that under the constitution the state has no right to take a man's particular services without compensation, and that the giving of expert medical restimony is a particular service within the meaning of the constitution."—*Kentucky Advocate.*

Vocalization after Removal of the Vocal Cords.—Mr. Lister, in removing a large papillomatous tumor from the larynx was obliged to remove the vocal cords also. The patient subsequently recovered, and in spite of the absence of the cords can talk quite distinctly. By careful examination, Mr. Lister discovered that vocalization was accomplished by the vibration of the aretyno-epiglottic folds. He had by previous experimentation found that the stertor in chloroform narcosis was due to the same form of vibration.—*Boston Med. and Surg. Jour.*

The Temptations of Physicians.—In the admirable valedictory address of Dr. William Goodell, before the graduating class of the medical department of the University of Pennsylvania, occurs the following passage, which cannot be too deeply pondered by every one of our profession:

"Do not, oh friends, oh brothers, do not, I beseech you, be cajoled, either by the ties of friendship, by the tickle of flattery, or by the glitter of gold, into doing anything that involves the loss of self-respect, and of professional dignity; into doing anything that is not right. Have "a keen and precious hatred" of everything bad, for strong, very strong temptations will be thrown in your way, hard, very hard to resist. The honor of a family is at stake, and you will be besought to save it. A man of doubtful sanity lies a dying, and you will be asked to yield to a friendly bias in giving evidence in favor of his mental vigor and testamentary capacity. A crime has been committed, and the tears and appeals of the criminal's kin will be brought to bear on you, to give such evidence as shall tend to make him irresponsible. A patient with some organic disease, or of intemperate habits, will wish to affect an insurance on his life, and you, fearful of giving umbrage, will be sorely tempted to testify to his soundness or sobriety. You will be called upon to explain the absence of some pleasure-seeking official, by giving a certificate of illness. When

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summoned to courts of law as medical experts or as medical witnesses, you will find it hard to resist an unbecoming bias toward your client. Before the paint on your signs is fairly dry you will be approached by those who spurn the tender name of mother. Turn, therefore, a deaf ear to all such appeals, and swerve not a hair's breadth from strict uprightness. He who barters honor and honesty for gold gains nothing but the contempt of those who use him as their tool. Remember, besides, that you will one day answer for it, unless you keep your hands and your hearts clean, before God and man."—*Medical and Surg. Reporter.*

The Bromides in Epilepsy.—Professor E. C. Seguin, M. D. in the *Journal of Nervous and Mental Diseases*, sums up his views on the use of the bromides in epilepsy and other neurosis in the following words:

1. In view of what we know of the physiological and toxic effects of the bromides, and in accordance with either of the two generally received hypotheses of their *modus operandi*, anæmia and debility, or congenital feebleness, contra-indicate prolonged use of the bromides.

2. The bromides are, on the contrary, well borne by persons of fairly full habit and good nervous power.

3. The bromides are indicated in cases of abnormally great irritability of the nervous system, in its motor (muscular and vaso-motor) and ideational tracts.

4. Epilepsy is so serious a disease, one which, if not interrupted, kills the patient or reduces him to dementia, that we are justified in using unusual and heroic measures in its treatment. Hence, the contra-indications named above are to be much less regarded in the management of this formidable neurosis.

5. As a corollary to the last proposition, I may state that I consider epilepsy to be the only disease for the cure of which we are justified in deliberately producing a degree of bromism.

Hysteria in Male.—Dr. Bolles has reported the following case to the *Boston Society for Medical Observation* A young man wassuddenly attacked with almost complete (hysterical) coma, and was found in that condition in bed one morning, occassionally sobbing, but not responding to any questions, nor to pricking, pinching, or touching the conjunctiva. Pulse varied from 100 to 120; temperature 100½°. There was free perspiration. He past urine of a light colour in large quantities. He improved a little upon the next day, but subsequently relapsed, and remained so for four days. The attack was brought on by some "amatory misunderstanding." and subsided immediately upon reconciliation taking place, leaving a condition of exhaustion for several weeks.

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THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY.

A WEEKLY JOURNAL OF MEDICINE, SURGERY AND THE COLLATERAL SCIENCES.

EDITED BY

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EDITORIAL.

THE FALL OF HOMŒOPATHY.

The present month has been made memorable by two notable events—the death of Tweed and of Homœopathy! These events have so much in common, as that both Tweed and Homœopathy were believed, by their followers, to be worthy of confidence, when, in fact, both were frauds, and both have come to untimely and violent deaths. Tweed has died of a broken heat, because he could not break the bars of his prison, and Homœopathy has committed suicide in the open streets.

For several years Homœopathists have shown signs of mortification and of humiliation when the finger of ridicule has been pointed to their absurd doctrine of infinitesimals; and one after another they have denied the faith in this once cardinal element of their doctrines—but only that they might contract the more valiantly for the doctrine of *similia similibus curantur*. But now they have pulled down this, the only remaining column upon which the edifice stood, and they lie buried and gasping beneath its ruins. The Homœopathic Society of this city has declared that it will no longer "obstruct science," or make itself the jest and amusement of a laughing world; and it has formally announced its intention in the future to use any medicine which experience had proven to be useful, whether it operated in accordance with the rule of *similia*, or of *contraria*, etc. In short to use what

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medicine they pleased without reference to rules or doctrines; and this is now, and always has been the precept and practice of the school of medicine from which, for the sake of gain—in order that they might profit by a stupid but popular delusion—they had formally separated themselves. The ground now taken by the Homœopathists is the only possible ground for any science to stand upon; and in admitting this, they have virtually, so far as they and their followers are concerned, terminated the existence of Homœopathy. As to the number of the deserters—those gentlemen who have taken the lead in firing upon and hauling down their own flag, say that not three genuine homœopathists can be found in this city—probably not one, not so many, perhaps, as were required to save Sodom and Gomorrah. They, the ungodly people, and their visionary doctrines are, therefore, to be sunk and buried forever beneath allopathic floods of sulphur.

An honest confession is good for the soul! So Tweed thought; but who will pay back to the people the money he has taken under false pretences?

We have one favor to ask of these gentlemen, and that is, that in their search for a new name in place of that which they have now repudiated, they will not call themselves "Doctors," but leave to us the sole and exclusive right to our ancient title.

Perhaps we may suggest that they call themselves "eclectics"—that is, men who do as they choose, or polypathists, or noodles, or anything else but doctors. For reasons which we do not feel obliged to give, we prefer not to be considered as belonging to the same family, or as in any way related to them for a generation or two to come.

There is something queer in the blood, or brains, or hearts of these unfortunate men, which will not be got out of them in a day, perhaps, not in a life-time. In the meantime, as our own family is already pretty large, and as the Alma Maters are very prolific, we can afford to wait awhile before we adopt the children of others.

LECTURES.

THE LATERAL OPERATION FOR STONE IN THE BLADDER.

A Clinical Lecture Delivered at the University Hospital

BY

D. HAYES AGNEW, M. D.

Professor of Surgery and of Clinical Surgery in the University of Pennsylvania.

[Reported for the HOSPITAL GAZETTE.]

This man has been suffering for the past 24 years, he is now about 30 years of age, from trouble with his urinary bladder. Lately his symptoms have increased greatly in severity. He now complains of a constant desire to urinate. This is particularly the case during the night. Immediately after the bladder is emptied he feels a burning

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pain in the end of his penis. He is obliged to strain considerably during defecation, as is very frequently the case where a vesical calculus exists. There may have been at some time a prolapse of the rectum consequent upon the straining. Upon the introduction of the sound it is immediately brought in contact with a calculus. The impression which I have on several occasions obtained has been that of a very large stone, but impressions are deceptive, much depends also upon the constitution of the stone.

In preparing the patient for the operation which I intend to perform before the class to-day, the first thing which we have done has been to get him into as good a condition as possible. This has been accomplished by the use of a strengthening and well selected diet, by the internal administration of the alkalies and the tincture of the chloride of iron, and by the employment of opium suppositories by the rectum.

The operation which I have determined to undertake is that known as the lateral operation for stone in the bladder. It is performed on one side of the perineum. If you will look at this model you will see that the superficial parts of the perineum have been removed in order to display the deep structures. Here, you see, is the bulb of the urethra, on either side are the crura of the penis. These crura separating as they do, leave the space into which we must work our way in the operation. The ischio-rectal fossa, as you know, divides between the rectum and the perineum.

To go through the various steps of the operation before performing it—you first divide the skin and superficial fascia, that brings you to the middle perineal fascia. Under this fascia is the deep perineal fascia, or the triangular ligament. This consists of two layers and it is with this part that we have the most to do.

In making the incision begin at the median line of the raphè and carry the knife towards the tuberosity of the ischium. You thus divide the fat and the middle perineal fascia. Deeper still you divide the transverse perineal muscle and the transverse perineal artery. The first bleeding that occurs is usually from this artery. After having cut thus far, feel for the grooved staff held in the urethra. Be careful not to carry the knife too far out towards the internal pudic artery. Now direct the point of the knife towards the groove and running it down the groove divide the prostate gland and open a way into the bladder.

Before beginning to operate I am careful to see that the table is firm and the light ample. As it is absolutely necessary to the success of the operation that the patients bowels be kept entirely closed for some days I gave orders that his attendant should administer a gentle purgative early this morning, and follow it by an injection. When the contents of the large intestine were all expelled, twenty-five drops of laudanum were administered.

Although I have sounded for, and found this stone upon many occasions hitherto, I intend to go through the same preliminaries again to-day. The operation for stone is such a serious one that it should never be undertaken unless the stone has been proved beyond

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question to be in the bladder. I am now perfectly satisfied that there is a stone. By attaching this extemporized sounding board I am able I think to demonstrate the presence of the calculus to all of you.

The next thing I shall do will be to inject a good quantity of water into the bladder. Now everything is ready, but first let me introduce the grooved staff. I have, you see, put it into the urethra and pushed it well up under the arch of the pubis. My assistant will maintain it firmly in this position. You notice that I have so arranged it that its handle almost makes a right angle with the plane of the patients body. I now kneel down in front of the table and by one or two well directed and rapid movements I lay open the parts and carry the point of the knife into the groove and so into the bladder. The water injected spurts out and with it a little blood. The bleeding, is, however, insignificant. All that now remains is the extraction of the stone. I shall use a pair of duck-bill forceps for that purpose. This stone is so large that I am afraid it will be no easy matter to remove it, though my incision was a free one. One point; be always very careful not to catch up any part of the mucous lining of the bladder with the forceps in searching for the stone. After tugging at it slowly but steadily for two, or three minutes I have been successful in removing the calculus and just see how large it is—about the size of a good sized hen's egg. Part of it has been broken off by the forceps and left behind in the bladder. These fragments must be carefully washed out by an injection of water into the bladder through the opening. The transverse perineal artery has been giving rise to some little hemorrahage, but it has been now securely ligated.

What will be the after-treatment? The man must be at once put to bed and a "draw" sheet be placed under him to soak up the urine and other discharges from the wound. As soon as the man recovers from the effects of the ether-narcosis I shall order the resident physician to give him one grain of opium by the rectum. When the traumatic fever, consequent upon the shock of the operation, has passed away, which will be in the course of a day, or so, we will begin to feed the patient and try to build him up rapidly upon a nourishing diet. I will not touch the wound for the present, further than to keep it clear of obstructions, until healthy granulations appear.

[On the fourth day after the operation the patient was progressing very favorably. The traumatic fever had been but slight and of very short duration. The only troublesome symptom was the persistent abdominal pain. This had, however, finally yielded to large doses of opium. The patient improved rapidly during the following week and had good sleep at night and an excellent appetite. Healthy granulations are beginning to appear and unless something unforeseen occurs, the man may be already considered as on the fair way to recovery. It has not been considered necessary to analyze the calculus to determine its chemical composition.—REP.]

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INCONTINENCE OF FECES.

A Clinical Lecture delivered at the College of Physicians and Surgeons, New York,

BY

ABRAHAM JACOBI, M.D.,
Clinical Professor of Diseases of Children.

[Reported for THE HOSPITAL GAZETTE.]

GENTLEMEN:—The child I now show you is brought to the clinic on account of a difficulty in controlling its passages. The child is seven years of age, and its attendant informs us that it cannot hold its feces, or rather that when it is taken with the desire to have a passage, it does not have time to undress and go to the proper place before the evacuation takes place. He has two passages a day, and soils his clothing on every occasion. This trouble has affected him for about a year, so that up to the age of six years he had no complaint of this kind.

On stripping the patient we discover quite a large swelling situated over the lumbar portion of the vertebral column. On questioning, we find that this tumor was congenital, and has existed in this situation ever since the birth of the child.

It might occur to you at once that there was some connection between this tumor and the symptoms complained of, on account of its situation over the lumbar region of the vertebral column. If this were so, we should expect the tumor to be in intimate relation to the spinal cord, and not situated entirely outside of the canal. Again, as the symptom for which he seeks relief has only existed for a short time in comparison with the age of the tumor, which was congenital, we should expect that it must have increased in size during the last year; but such is not its history. The neighboring organ, the bladder, which would also be probably affected if the tumor exercised any influence on the complaint, is not involved, as the boy holds his water perfectly well. His present incontinence of feces is, probably, more of a local or peripheral nature than due to a central disturbance. If there was a disease of the lower part of the cord, resulting in incontinence of feces, we should have incontinence of urine likewise.

The tumor is situated in the location in which we most often find spinabifida. Not unfrequently we have a lipoma in this same situation, and one of these diseases has often been mistaken for the other. Not rarely the two exist together, and may occasion considerable uncertainty, both as regards diagnosis and treatment.

An awkward case of this kind was presented in our clinic some years ago. This case was a doubtful one, though the existence of a lipoma was pretty certain. It was decided, however, that nothing should be done. One of the gentlemen connected with the clinic proposed to remove the tumor, notwithstanding, and took the patient to his office. He proceeded to the operation, and the first thing he saw was an undue amount of cerebro-spinal liquor escaping. The child died eighteen or nineteen hours afterward.

This goes to show that lipoma, in this situation, and spina-bifida

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often go together, and to declare the case before us one of the former tumors, without the complication of spina-bifida, would be further than I care to go.

There may have been spina-bifida in this case during fœtal life. It may have closed up afterward, or the opening may still exist, though it be quite small. We often see tumors in this region which have commenced as the result of spina-bifida, but the entrance to the spinal canal has become narrowed and, perhaps, finally obliterated. The sac has behaved in such a way as to form a cyst. Such tumors have often been removed with immunity.

This lipoma is not increasing in size. It could undoubtedly be removed, but there is no hurry to operate, as it is doing no harm. I have seen them remain twenty or thirty years without undergoing any change. Besides, imagine the consequence of an operation, if beneath the tumor there is a communication with the spinal canal. There might be only a cyst of the kind I have just described, but the slightest cut might reopen it and then serious results would follow. I should certainly advise the mother to let the child carry his tumor as it is and then no harm at all will be done. If it grows larger and causes inconvenience or annoyance it may then be removed.

The child sometimes complains of a little pain. On careful palpation, it appears as if the spinous processes were slightly receding. This, however, is deceptive, for whenever we have a tumor seated over a level surface, the surface underneath seems to be receding. You will recollect what a deceptive feeling you get with a cephal-hæmatoma, which gives you the impression that the bone over which it is situated is receding. In the case before us I am pretty positive that I can feel a tolerably normal spinous process underneath the tumor.

But to return to the incontinence of feces. From what cause this arises we do not as yet know. The person who is with the child is not well acquainted with his history and cannot tell us whether or not he ever suffered from diarrhœa or dysentery. If he has suffered from that complaint it would be sufficient to account for the trouble. On account of the inflammation and the successive acts of straining, with the tenesmus to which it gives rise, the mucous membrane becomes lax and flabby, and that is the reason we so often see prolapsus of the rectum and analogous conditions following these diseases.

There might be a polypus in the rectum which might also give rise to the state of affairs here seen. There might be simply imperfect contractions of the sphincter ani due to anæmia and debility. We often see such cases in rachitic children, the muscles being incompletely developed and acting imperfectly. In such cases iron or cod liver oil alone will not only be useful in improving the general condition, but will likewise cure the local troubles.

We will now examine and find the condition of the rectum and see if we can discover a cause. If I should introduce my finger through the anus with less trouble than usual and should find nothing inside, the condition would probably be due to the simple œdematous con-

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dition of the mucous membrane following diarrhœa. We find, as you observe, that the sphincter is flabby and has not much power of contracting, and the mucous membrane inside soft and loose.

From these facts, I believe this incontinence of feces to be of local origin and to be in no way connected with the external tumor. I also think that that is a simple lipoma which may be connected with no spina-bifida, or one that probably closed after birth. There is no history of paralysis, etc., and I think we can safely exclude disease of the spinal cord from our diagnosis.

A few words now as regards treatment. The general condition of this child is not very poor. We might improve it and thus increase the nerve power by administering strychnia and similar nerve tonics internally, but this would be a rather roundabout way. If the child were in the hospital I should inject a solution of strychnia subcutaneously every day, in the neighborhood of the rectum. As under the present circumstances we cannot do this every day, I should propose to give it in the form of an ointment, say a scruple of the extract of nux vomica rubbed up with four to six drachms of fat to be applied in the rectum two or three times a day.

I should also advise cold injections for their cooling and strengthening effects. Of the ointment, a piece about the size of a couple of coffee beans may be used morning and evening, preceded by the injection which cleans the gut and allows of the absorption of the medicine. I think that under this treatment improvement will be very rapid.

ORIGINAL ARTICLES.

THE TREATMENT OF DIPHTHERIA.

BY

LOUIS WEIGERT, M.D., AMSTERDAM, NEW YORK.

Reading the report of the Board of Health of New York, which stated the mortality of diphtheria in that city and Brooklyn to be 40 per cent., I think it my duty to acquaint the profession with some facts concerning that terrible malady—facts which I have gleaned during my residence here, hoping and believing that it might be the means of reducing the death rate. When I arrived here on the 11th of last January, I was informed that diphtheria had raged in Amsterdam and the surrounding country since early fall as a most fearfully malignant epidemic, which had already deprived almost every family of one or more of its members, and that all those attacked, with the exception of at the most 10 per cent., had succumbed to the disease. Investigating the causes of death, I refer to the immediate causes, I learned that by far the greatest majority had died of asthenia, induced partly by the prostration incident to the disease, partly by the high temperature which literally consumed the patients, and last, but not least, by the want of proper nourish-

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ment and stimulation. Only a very small number died of asphyxia. The following is an account of my observations and the results that I have thus far obtained. As a rule, I was called from 12 to 24 hours after the patient began to complain of the following symptoms: Vomiting, headache, pain in the bones, sore throat, fever—either one or more, or all combined. Their uniform condition was: temperature from 103 to 104 1-2° in axilla (thermometer allowed to remain in situ for five minutes), pulse 120 to 180, cervical glands enlarged, tonsils and pharynx inflamed, the former presenting in all cases a varying amount of membrane usually of about the size of a five cent nickel, the exudation forming a continuous membrane in all but five cases, appearing in the latter in small scattered patches. Both tonsils were involved in 90 per cent. In two cases pressure upon the larynx was painful. I have now treated 50 cases, only two of which have terminated fatally. Convinced that nothing but heroic treatment could combat successfully with this scourge, I decided upon the following treatment which I have pursued in all the cases. I prescribed no less than gr. v. of sulphate of quinine (either in gelatine coated pills, or in a mixture with the compound elixir of liquorice) every two hours, and as a rule, that amount was sufficient to reduce the temperature after about 12 hours to below 101°, at or below which degree I maintained it during the entire course of the disease. I never decreased the dose of quinine first given, but increased—according to requirements—the intervals between the doses; in some cases I was compelled to administer as much as gr. viij every two hours to obtain the desired effect, and that even to as young a child as six years old. The tinnitus aurium and other symptoms of cinchonism were very mild if they existed at all, being entirely absent in about 33 per cent. In some instances I noticed that after the disease had run its course the continuance of the use of quinine would maintain the temperature at from 1 1-2 to 2 1-2 degrees above the normal, the fever only subsiding after the withdrawal of the drug. I gave to all the following mixture: Kali. chlor. ℥ ij; aquæ et glycer, aa ℥ viij; tinct. fer. muriat, ℥ ss;—(reducing the amount of chlorate of potas. in very mild cases to ℥ i ss. or even ℥ i.) In this proportion there is, of course, an excess of potassium chlorate, which is deposited in minute crystals. I directed the bottle to be well shaken and ℥ i. to be given every 15 minutes, and as I did not permit the imbibition of anything within 5 minutes after each dose, I obtained both the constitutional and the local effects. I continued the use of this, day and night, until I could perceive that the extension of the membrane was checked, and that occurred, as a rule, after 24 to 72 hours; only in three cases did I fail to make any perceptible impression upon the local disease. On the 3d to 5th day the membrane begins to alter in color, it becomes a dark, dirty gray; and on the 6th to 7th day it commences to fall off, usually in small fragments, so that on the 8th to 9th day the throat is entirely clear; after which time I still continue the use of the potassium chlorate mixture for 2 to 4 days, of course in diminished doses. I have noticed one very remarkable effect of the

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chlorate of potas., viz.: after the absorption of 4 to 6 ounces, generally about the 7th day, there appeared in about 35 cases (the balance had taken much smaller amounts), an eruption which in 6 cases bore a most striking resemblance to measles and scarlet fever; on the first day to the former, and 24 hours later to the latter, covering the entire body and face and disappearing by gradually fading out, but only after the discontinuance of the potassium chlorate. I administered gentle cathartics daily, unless the patients had natural evacuations. I never attempted to check any emesis (which was often induced by the drugs), believing that it reduced the fever, and, towards the termination of the disease, certainly aided in the expulsion of the membrane. During the entire course of the malady I had a wide strip of flannel, wet with ice-water, applied to the patients' throats and covered by a dry flannel bandage, and had the former renewed as soon as it became dry and warm (at first every 3 to 4 minutes.) It was gratifying to see how well the poor sufferers liked these cooling applications, especially after they had had pork, pepper, mustard, kerosene, etc., around their necks for some hours prior to my arrival, and that was the case in 48 out of the 50. Even the youngest children—those but 3 years old—would remind their attendants of the necessity to renew the bandages. It is needless to say that I insisted upon thorough ventilation of the sick-room.

And now as regards nourishment: The patients received 2 quarts of milk, one pint of beef-tea—the extract of one pound of meat, 6 eggs and 2 ounces of brandy daily; these, the minimum quantities, they were forced to take, but were allowed to have as much more as they would accept. As soon as convalescence began, I permitted the judicious use of solid food. In 3 cases—one 2½, and the other two 4 years old—there was hoarseness and dyspnœa (severe only in one), beginning in two on the 5th day, and in the other on the second day; to them I administered emetics (1-12 gr. of sulphate of apomorphia, hypodermically), daily, and had them inhale the vapor of water every 1-2 to 1 hour, for 5 minutes; all three recovered. Fetor was present only in 3 of my cases, whereas it was a constant occurrence in others.

My two fatal cases both died of collapse, and both after convalescence had set in; one was a girl, 4 years old, in whom the disease had been exceptionally severe, and the other was a lad, 13 years old, who had always been feeble and whose lungs were affected. The local manifestation of the disease was confined to the throat in all my cases excepting in the first-mentioned fatal one.

Doctor R. J. Cullen, a young physician who has also settled here recently, has carried out this treatment in all his cases of diphtheria, amounting to about 20, all of whom recovered. His observations fully coincide with mine; one of his patients was but 8 mos. old.

In the above I have mentioned no new drug for the treatment of this disease. I have used those hitherto known to be efficacious, and employed by many; hence my only claim is that I have obtained from them their full effects.

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HOSPITAL RECORDS.

CHARITY HOSPITAL, NEW YORK.

Reported by O. A. GORTON, M.D., HOUSE SURGEON.

SPASMODIC STRICTURE OF URETHRA.

J. R.—35 years of age—admitted to hospital Dec. 14th, 1877. Since childhood patient has been unable to retract his prepuce. He contracted gonorrhœa in 1865, when the discharge lasted one year; again in 1867—discharge lasted six months; again in 1870, when the discharge continued a year. Patient stated that during the three years before admission his "bladder had been weak," and he had suffered constant pain in the "small of the back" and behind the scrotum. When passing his urine, the stream had been small. At the time he came to the hospital patient had a urethral discharge, that began two months before, after exposure to venereal disease. The discharge was then of ordinary gleet-like character. Patient was treated with bougies passed every third day, and a stricture at the membranous portion dilated from No. 1 Eng. to No. 8 Eng. by the end of January. The use of instruments always caused a great deal of pain and considerable hemorrhage. February 1st the patient came under my care. His preputial orifice was barely large enough to admit No. 35 French sound. The sub-preputial space had, since admission, been kept clean and was free from inflammatory action. With No. 4 Eng. bougie, an obstruction could be felt at the membranous portion of the urethra, and a bulb of larger size showed that the stricture was linear. Considerable difficulty was met in passing No. 8 Eng. sound into the bladder. The pain was severe and hemorrhage abundant. Up to this time the gleet had not been diminished by treatment. I told my assistant, Dr. Culpepper, that I believed the stricture to be spasmodic, and asked him to make a longitudinal incision through the prepuce upon the dorsum, long enough to allow easy retraction of the foreskin; and, after retraction, to stitch the cut edges together transversely.

Two days after the operation, a No. 16 Eng. sound—the largest the meatus would admit—was passed into the bladder and met with no obstruction at any point, and gave rise to no pain or hemorrhage. In one week after the operation, the urethral discharge had entirely ceased and micturition was regular. At patient's own request he was discharged.

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TRANSLATIONS.

SURGICAL CLINIC AT THE HOSPITAL SAINT-LOUIS, ON A FORM OF SUPPURATIVE OSTEITIS.

BY
M. S. DUPLAY.
Reported by Et. Golay.
(*Le Progrès Medical.*)

GENTLEMEN—You have just been allowed to examine in bed No. 61, ward St. Augustine, a young man aged 23 yrs., who entered our wards some days ago to be attended to for an affection which he has in his left tibia.

Here, in a few words, is his history:—Three years ago there appeared, without any appreciable cause over the crest of the tibia, and at about the union of the inferior fourth of that bone with its superior three-fourths, a tumefaction of about the size of a filbert, painful on pressure, and which troubled him in walking. It invaded little by little the internal surface of the tibia, taking the form of a diffuse swelling.

The persistence of this state of things causing him anxiety, he decided at the end of a month to enter the hospital of Reims. He was there treated by rest and resolvent frictions with "*Napolitain*" ointment. Under the influence of this treatment the tumefaction diminished, the pains disappeared, and after three months' stay at the hospital he was able to go out and return to his occupation of shop boy. But, under the influence of walking, and of fatigue, the pains very soon having reappeared, he placed himself under the care of a charlatan, who advised frictions with some kind of pomade.

There very soon appeared, on the most prominent point of the tumefaction, an abscess, which opened spontaneously, gave issue to pus, and the opening of which remained fistulous. Thus he went on for about eight or ten months after his departure from the hospital of Reims, that is to say, till about fourteen months after the beginning of the disease. Through this fistula he did not see at any time a splinter of bone or any osseous fragment, no matter how small, find its way to the exterior. The fistulous tract and the pains persisting, the young patient decided after some time to re-enter the Hotel-Dieu at Reims, and after three months' of sojourn at this hospital, the fistula was, he says, completely closed. About a year ago he left, but during this period the same pains have reappeared in different attacks, and the patient has passed through various alternations of better and worse states, the pains reappearing when he undertook to follow his occupation again, and disappearing when, on the contrary, he ceased working and took rest. It is in order that we shall put an end to this state of things that he lately entered our service.

To-day we find that the left tibia is the seat of a very manifest tumefaction, exclusively localized on the diaphysis of the bone, the inferior epiphysis of the tibia having preserved its normal shape. Indeed, the swelling begins only about four fingers' breadth above the malleoli, and reaches to the middle part of the bone over an extent of

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about twelve centimetres. The tumefaction is gradually lost above and below in the neighboring parts, wherefore the internal surface of the tibia appears to be bunched out, and its crest greatly elongated and deformed. The internal surface of the diseased bone, at the point of greatest prominence of the tumefaction, measures seven centimetres in size, while the healthy tibia, measured at the same level, measures only four.

Again, the tumefaction is not limited to the internal surface of the bone, for if we seek to explore the external surface, we find the muscles of the anterior region of the leg raised from their level by a deep arching. The augmentation of volume, then, exists through the whole thickness of the bone, and not only at a point confined to the surface.

The skin has remained very nearly healthy through the whole extent of the tumefaction. It is not the seat of any redness, and has preserved its mobility over the subjacent parts, except just at the point which has been the seat of an abscess and of a fistulous opening during the course of the last year.

But, I beg you to remark, gentlemen, that this slight adhesion is superficial, and is not marked on the exterior by any depression, any sinking down of the skin, like that which appears when the bone underneath has been attacked by necrosis. As regards the sub-cutaneous cellular tissue, it appears thickened throughout the whole extent of the tumefaction. Palpation, moreover, reveals a marked difference in temperature between the seat of the tumefaction and the neighboring healthy parts.

The spontaneous pains are now very slight, the patient only complaining sometimes of lancinating pains in the diseased parts, with some radiations towards the knee. When he suffers, he often feels no more than a vague sensation of *malaise* in the whole extent of the leg; on the contrary, the pains that are provoked are quite severe, and pressure over the tumefied part causes the patient to draw away his leg quickly.

This sensibility has its maximum intensity over the most prominent part of the tumefaction, and in an adjacent point of the inferior part of the tumor, where the slightest touch allows of the discovery of a small osseous projection in the form of a needle, which raises up the integuments.

As regards his general condition, the patient, if he is not vigorous, presents at least all the appearances of a fair constitution. Besides, he asserts that except the affection that brings him to the hospital, he has always enjoyed excellent health.

With an affection which lasts three years without improving, we can, gentlemen, say that he suffers from a chronic disease, and we may add, from a chronic affection of an inflammatory nature, for it presents three of the characteristics of all inflammation—swelling, heat, and pain. The single phenomenon of redness is wanting; but you know that this is ordinarily so in deep inflammations, especially when they have a chronic course. Finally, have we not, with our patient, a still further proof of the inflammatory nature of the disease in the outward evidence of suppuration?

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We have here, then, an inflammatory lesion localized about the tibia. If I insist on this fact, gentlemen, it is in order that we may immediately eliminate the diagnosis of all tumors of the tibia, such as exostoses and periostoses. I add, besides, that it is not a pure and simple periostitis, for this affection has a tendency to progress towards resolution, or to terminate by the formation of a sub-periostitic abscess; and moreover, if in our patient the periosteum participates in the inflammation, which does not appear doubtful, the swelling of the whole of the tibia proves that the osseous tissue itself is inflamed.

What is the nature of this osteitis?

As regards the etiology, we have not found in our patient any external cause, any traumatism; he asserts that he has never received even a slight injury over the tibia. The occupation of the patient—has it played any part as a predisposing cause? It is possibly the fatigue, for he is a shop boy, and this keeps him constantly about; but it must be acknowledged that this is a very vague cause. Could it be that the general condition of the patient has given rise to it? No, for we have not found in his antecedents any sign of scrofula, or any syphilitic taint. Besides, he is young—only 23 years old—and it would be an exception to see at this age tertiary manifestations. Might the affection be of rheumatismal origin? This is very little probable, for our patient has never suffered from rheumatism. And yet he states that when a child he was exposed to the action of cold and damp; he slept on the ground floor of a little house in the country, where his bed rested on the ground, destitute of flooring. Taking into account even this influence, we must still say that the cause of this osteitis is not clear.

As regards the nature of the lesions, you must be aware that osteitis presents itself under the most various forms. We must then accurately determine what is the variety of osteitis of which our patient offers an example.

We can at once exclude the whole class of *epiphyseal* and *juxta-epiphyseal* osteites, so-called because they develop at the point of union of the diaphysis and the epiphysis, and show themselves at the time of the growth of the bone, when the nutritive activity around the cartilages is most vigorous. Inflammatory irritation may then be considerable as a consequence of the physiological superactivity which takes place in the locality.

With the patient who is the subject of this lecture, the affection is evidently located in the diaphysis; it is a *diaphyseal* osteitis.

Now, there have been observed in the diaphyses of the long bones a large number of varieties of osteitis, which are distinguished, in the first place, by the characteristic that some are accompanied by suppuration, while in the others there is no suppuration. Among the latter must be mentioned *thickening hypertrophic* osteitis. With our patient the suppuration has already taken place; he has presented an abscess of the tibia, of which the opening remained several months; we must therefore place his case in the class of suppurative osteites.

But the suppuration of the bone is often secondary and symptomatic of a primitive lesion of the osseous tissue, such as tubercles of

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the bone, caries, or necrosis. Does there exist in our patient one or the other of these three affections?

Tuberculous deposits are very much rarer in the bones than was thought by Nélaton. They are seated usually in the spongy tissue and show themselves almost exclusively in patients suffering from pulmonary tuberculosis. This is not the case in our patient.

Caries, the pathological nature of which has been so well elucidated by Ranvier, and which is characterized anatomically by fatty degeneration of the osseous elements, attacks by preference the spongy tissue, of which it causes softening and suppuration. There result from this, fistulæ that never dry up, giving issue to pus sometimes full of a kind of osseous powder. If we introduce a probe through these openings, we penetrate the osseous tissue, breaking up the fragile and degenerated partitions of the spongy tissue.

In our patient the osseous lesion attacks the compact tissue; it is confined to a portion of the diaphysis; aud the fistula, which has existed, has closed very much too quickly for us to consider at all about the existence of caries.

Might there then exist a limited necrosis?

You are not ignorant of the fact that the portions of bone attacked by necrosis, and which have been designated by the name of sequestra, become separated from the living parts when they cause the phenomena of long continued suppuration. In these cases we see fistulæ which remain until the complete expulsion of the sequestra. Moreover, if we introduce a sound or a probe through the cutaneous fistulæ, we reach a hard osseous surface, more or less roughened, and which on knocking gives a sharp and characteristic sound.

In our patient, nothing indicates that he has had, or that he really now has, a necrosis. The swelling of the bone is very limited; the fistula which was produced and which has quite closed, only persisted some months, and has not given passage to any sequestrum, no matter how small; and moreover the inflammatory phenomena have never shown, and do not now really show the degree of intensity which they present in necrosis.

The form of suppurative osteitis of which our patient presents an example cannot, then, be assigned either to tubercles, caries or necrosis. He has a peculiar variety of idiopathic osteitis, of which it now remains to me to speak to you.

From an anatomical point of view, it consists in the formation, in the middle of the bone attacked by condensing or rarefying osteitis, of cavities filled sometimes with pus, and sometimes with fungosities.

In the first case we may say that there is an intra-osseous abscess; in the other, a lesion which has not received any special name, but which may be called fungous or lacunary.

Here, in a few words, are the clinical characteristics which allow us to arrive at the diagnosis of these forms of osteitis. We discover, first, a swelling of the bone, limited to a point quite circumscribed in its extent. Soon the swelling is accompanied by pain, very variable in its intensity and in its characters; sometimes quite severe and arising in paroxysms often without any appreciable cause; it is at

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other times dull and resembles more a simple sensation of uneasiness and malaise in the limb than a true pain. But with all patients it has the very special characteristic of being intermittent, of coming and disappearing without known cause. Moreover, it shows itself particularly when the patient walks or fatigues himself a little, disappearing again when he takes rest. The same symptoms may last almost indefinitely without modification if a special treatment does not put an end to them.

When we find an osteitis presenting these characters we should suspect that it arises from an intra-osseous abscess, or from that form anatomically characterized by the presence in the thickness of the bone of cavities filled with fungosities.

Analogous symptoms may, moreover, show themselves in certain varieties of thickening, non-suppurative osteites, accompanied by sharp pains, and to which M. Gosselin has lately called attention, designating them by the name of osteites of the *neuralgic form.*

We may then, at the beginning, hesitate in the diagnosis, but thickening osteitis of the neuralgic form, without abscess, without fungosities, is observed especially to follow traumatisms, and is not accompanied at any time by suppuration. On the contrary, osteitis with intra-osseous abscess or with the lacunary spaces filled with fungosities, does not delay in giving rise to abscesses which open spontaneously or are opened by the surgeon. When it reaches this stage, the diagnosis may perhaps be established, according to my own experience, on solid foundations. In those cases to which I make allusion sometimes the pus issues from the bone itself, sometimes from the surface of the periosteum. These sub-periostitic abscesses, accompanying a limited swelling of the underlying bone, have a very great clinical importance; they almost always indicate the presence of an intra-osseous abscess, or at least a limited alteration of the subjacent bone, consisting in cavities, more or less irregular, inclosing fungosities. We may ascertain about them after their opening, for the probe encounters, instead of a denuded surface, the thickened periosteum.

I have several times had occasion to treat cases of this kind. I have in particular observed a patient at Saint Antoine, who resembled in certain respects the one who occupies our attention to-day. In that patient the repeated reproduction of sub-periostitic abscesses without exfoliation or bony denudation around them, caused me to diagnosticate an intra-osseous abscess, and trephining of the bone allowed me to evacuate a gathering of pus having its focus in the thickness of the bone.

The suppuration which accompanies the form of osteitis that I am here enabled to study, as I have said, issues from the bone itself, and not much from the periosteum. In this case the external opening communicates with the cavity of the abscess or with the cavities filled with slight fungosities in the thickness of the bone; the probe introduced in the fistula penetrates into the osseous substance, but instead of giving the feel proper to caries or necrosis, on which I will not dilate, it traverses a tract of variable form and extent, the walls of

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which are resistant, not friable as in caries, and the cavity of which does not enclose any sequestrum, no matter how small it might be.

The form of osteitis to which I have just drawn your attention, may be met with in the neighborhood of the epiphyses. We have an example of it in No. 32 of the male ward; and in that case it followed epiphyseal osteitis. When it attacks the diaphysis of a long bone it seems to me its pathogeny ought to be reconciled with that of epiphyseal osteitis.

As the bone augments in length at the expense of the epiphyseal cartilages, it takes its thickness, in the intermediate portion, from the internal and external periosteum. It exceeds itself around the periosteal laminæ, at the time of its greatest growth, a super-activity in the formative work of the bone, causing, under certain unknown influences, thickening of the normal boundaries and taking the character of a true inflammation.

I conclude, then, in saying that in the case that now engages us, we do not have either a symptomatic osteitis from tubercles of the bone, from caries, or necrosis, nor of the thickening osteitis of the neuralgic form described by M. Gosselin, but very plainly an interstitial osteitis accompanied by intra-osseous abscess, or cavities filled with fungosities.

The disease is relatively benign, in the sense that it never compromises life, and that it does not even change in any way the general health; but it is a very annoying affection, quite painful and one which may last for long years without a tendency towards cure. It is thus, because the abscesses may remain imprisoned in the thickness of the bone for several years. This depends on the greater or less thickness of the osseous tissue which separates the abscesses from the external parts. It is only when a very active inflammatory process is developed in the superficial laminæ of the bone, and softens them in a more or less circumscribed point, that the abscess can open itself externally. It then remains open during a greater or less length of time, sometimes indefinitely; but the fistula may close to open anew, however, at least when other openings are not produced in the neighborhood. In all these cases it is rare for the cure to take place spontaneously, and the hollowed cavities in the thickness of the bone nearly always remain so as to compel operative interference.

General treatment has no influence on the cure of this affection, which goes very far to prove that the pathogeny ought to be sought for very much more in a superactive state of the normal physiological working in the formation of bone, than in a peculiar diathetic condition of the patient.

Meanwhile, as the exact diagnosis cannot be made at the beginning of the affection, before the appearance of suppuration, we should commence by prescribing rest, resolvent frictions with "Napolitain" ointment, or with revulsives, such as blisters, or the application of the actual cautery, to the seat of the disease. This medication, besides, temporarily alleviates the condition of the patient; but very soon the same phenomena do not linger in reappearing, and it is only when the affection has already lasted a long time, or when its progress has

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been very attentively followed, that we can suspect the existence of this form of osteitis with abscess or fungous cavities, about which I have just been talking.

The diagnosis once well established there is nothing other than surgical interference that is capable of curing the disease, and the only treatment consists in the trephining of the bone, where there is evidence of the cavities which it encloses.

In my former patient of Saint Antoine, of whom I spoke to you a moment ago, I decidedly announced the existence of an abscess of the tibia, and trephining of the bone showed that I was right.

In our present patient I am less positive as regards the presence of pus; but, in default of a true abscess, I feel certain enough to tell you beforehand, that we shall encounter on a level with the tumefaction of the tibia, one or more hollow cavities in the thickness of the bone, and full of fungous growths. I add, that in opening the abscess, or the fungous cavities, and freely enlarging these cavities with the gouge, we shall hasten the ultimate cicatrization, and we shall relieve the patient of an affection which has troubled him for three years.

We shall perform this operation before you. We shall make a crucial incision over the most prominent part of the tumefaction; we shall detach the periosteum; and then by the aid of a small trephine or simply with the gouge, we shall cut away the superficial part of the bone, and in this manner penetrate into the cavity that we suppose to exist. This will allow us to give vent to the pus, if it exists, or cut away all the fungosities and expose the osseous walls of this cavity. The application of Esmarch's bandage allows us to operate without being annoyed by the escape of blood, and to judge exactly of the nature and extent of the lesions.

Note.—The operation that we have just performed confirms the diagnosis that I had given to you. After having incised the integuments and detached the periosteum, with the scraper, we found that on a level with the most prominent point of the tumefaction the superficial lamina of the bone was reduced to a few millimetres in thickness, and that it opened up an intra-osseous cavity of the volume of a small filbert, having irregular walls, covered with fungosities, and containing a bed of thick and whitish pus. From this cavity went a small canal, directed upward and downward, and which came out on the surface of the bone, precisely in the point corresponding to the cutaneous cicatrix of the former abscess. We laid open the cavity and the tract with the gouge, and smoothed over the osseous surfaces with the chisel and mallet. A little ball of charpie, soaked in carbolized water, and introduced into the osseous cavity, then covered by an ordinary dressing, will constitute the after treatment.

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PERISCOPE.

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General Surgery:
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SAMUEL B. ST. JOHN, M.D.
Orthopedic Surgery:
NEWTON M. SHAFFER, M.D.
Practical Medicine:
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HEREDITARY GONGENITAL LUXATION OF THE CRYSTALLINE LENS.

At a meeting of the Med. Soc. of London, Jan. 14, Mr. Wordsworth exhibited 6 persons of one family with congenital displacement of both crystalline lenses. They were a Mrs. H., two sons and their three children. A third son of Mrs. H. is also affected in the same way, and she says her own father, his youngest brother, and her grandfather, had the same affection. If this is true, there is a series of ten cases in 5 successive generations. They all complain of near-sightedness, and by oblique illumination or by the ophthalmoscope the lens is seen to be displaced, its edge being visible in the area of the pupil. In distant vision they look through the part of the pupil which is not occupied by the lens, but in near vision they look through the edge of the lens. S. B. ST. J.

THE OPHTHALMOSCOPIC DIAGNOSIS OF TUBERCULAR MENINGITIS.

Bouchut (*Gaz. des Hop.*) calls attention to the importance of examining the eye in brain diseases, in a series of 472 cases of tubercular meningitis, 463 of which showed marked neuro-retinitis or tubercular choroiditis, noticeable from the commencement of the disease, when the diagnosis was still doubtful, the child being perhaps only a little dull, with headache and some fever and vomiting. The ophthalmoscopic signs are modified from day to day, and become effaced as death approaches, so that the advent of death may be recognized in the eye. The lesions are often alike in both eyes, but sometimes more marked in the eye corresponding to the more affected cerebral hemisphere. In ordinary tubercular meningitis the exudation in the papilla is less marked in quantity, opacity and whiteness than when it results from encephalitis or cerebral tumor, and it does not obstruct the nerve circulation so much and is not so often accompanied by hemorrhages. The nerve at first swells and reddens, then becomes of a greyish tint, and the edges grow a little diffuse, this diffuseness increasing until the outline is quite lost. The arteries become gradually

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smaller, the veins filled with thromboses and sometimes rupturing so that blood is effused beneath their outer coats, forming primary false aneurisms of the veins.

Tubercular choroiditis also occurs, but in less proportion than we might expect. In the 472 cases, Bouchut found it in only 39. It presents whitish miliary granulations, like grains of sand at first, but increasing considerably in size. They are brilliant in the center, devoid of apparent vessels, but often have a retinal vessel lying over them. The mechanism of formation of these lesions Bouchut supposes to be that, the repletion and stasis of the cavernous sinus, by obstructing the ocular circulation, induces tumefaction and œdema of the papilla, with distension and rupture of the retinal veins. Schwalbe thinks the serous infiltration of the sheath of the optic nerve (which communicates with the subarachnoid spaces) induces strangulation of the papilla and hyperæmia of the veins; but Bouchut found that the infiltration of the sheath often existed without inducing any cerebral symptoms. S. B. St. J.

THYMOL AS A REMEDY IN SKIN DISEASES.

Dr. H. Radcliffe Crocker (*Brit Med. Jour.*, Feb. 16, '78,) has been using thymol to advantage in psoriasis, eczema, lichen planus, pityriasis versicolor, etc. He employs the following formulæ:

1. An ointment, consisting of one ounce of vaseline, and from five to thirty grains of thymol.

2. A lotion, consisting of thymol, five grains; rectified spirit and glycerine, each one ounce; water sufficient for eight ounces.

In the three former diseases, he found the ointment beneficial in sub-acute cases, in fact, in such cases as are commonly treated with tar. In pityriasis versicolor, he used the lotion.

As thymol is quite irritating in strong solution, it cannot be employed in cases that are at all acute. Being colorless, and of not unpleasant odor, it presents manifest advantages over tar.

H. G. P.

NEWS ITEMS AND NOTES.

A Question of Ethics.—The following notice, clipped from the *New York Sun* of March 10th. 1878, and of which, of course, the great "revolutionist" was ignorant, must be very annoying to the gentlemen named therein, and especially to the principal.

"The Asylum For Idiots.—Dr. L. A. Sayre's System for the Amelioration of its Inmates.—In response to an invitation of the Commissioners of Charities and Correction, Dr. L. A. Sayre, eminent in cases of idiocy, visited the Asylum for Idiots on Randall's Island yesterday, with a view to devising means for the amelioration of the condition of its inmates. He was accompanied by Commissioners Brennan, Cox, and Bailey, and by several medical experts, among whom were: Drs. F. N. Otis, McLean Hamilton, P. B. Porter, James

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S. Green of Elizabeth, C. Van Bibber of Baltimore, Nassau of Burlington, Iowa. C. H. H. Sayre of New York, Crenshaw of Kentucky, Cuddiback of Bellevue Hospital, and McDonald of the Asylum for the Insane on Ward's Island.

They were conducted through the institution by Dr. Howard, the physician in charge, and by Mr. Osborne, the Superintendent. Dr. Sayre operated upon a number of patients, many of whom are considered as hopeless idiots. In the cases of males he removed the elongated prepuce wherever found, and for females he performed operations similar in character. Dr. Sayre has performed similar operations in like cases, with marked success, and these cases will be watched by the medical profession with great interest."

In the January, 1878. number of the *Richmond and Louisville Med. Jour.* (*page* 78) when Dr. Sayre wished to invalidate the statement of a *medical* gentleman, he said "I am not accustomed to have strangers present when I am engaged in so delicate an operation as the application of electricity to the leg of a young lady." Are, we then, to think that Dr. S. considers the removal of the clitoris as a less delicate operation than that mentioned above? or does he regard Commissioners Brennan, Cox, and Bailey as *professional friends*? Whatever may be our opinions in regard to these questions, we cannot but be forced to the conclusion that our code of Ethics is a dead letter for those who wish to violate its spirit.

Replantation of Teeth.—Having found that sound teeth which had been accidentally torn out could again be firmly fixed in their alveolar sockets, Dr. Weil, of Munich, made the attempt to replant diseased teeth. They were removed under anæsthetics, the nerve canal cleansed, the diseased periosteum scraped off, the roots, if containing exostoses, clipped off, and the tooth replaced and fastened with strong silk. In seven days they seemed to be firmly fixed, and at the end of three weeks no further restrictions were placed upon their use. Weil reports three cases in which this plan proved satisfactory.—*Am. Med. Bi-Weekly.*

The Chair of Dermatology at the Royal College of Surgeons, England, which has become vacant by the resignation of Mr. Erasmus Wilson, will, it is understood, be filled by the appointment of Mr. Jonathan Hutchinson.

Extirpation of the Spleen.—This operation has been done for traumatic cases about 20 times—all successful. Eighteen operations have been done because of pathological changes in the organ, 12 of which have been fatal.

Homœopathy.—A conscientious pharmacist, says the *Pharmac Centralhalle*, receiving a prescription from a homœopathic physician in Vienna for belladonna, a tenth dilution, dispensed distilled water; but the medicine was sent back with a request to dilute it yet more, as it was still too powerful.—*The Clinic.*

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THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY.

A WEEKLY JOURNAL OF MEDICINE, SURGERY AND THE COLLATERAL SCIENCES.

EDITED BY

EDWARD J. BERMINGHAM, M.D., and FREDERICK A. LYONS, M.D.

H. H. KANE, M.D., Associate Editor.

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EDITORIAL.

THE AMERICAN MEDICAL ASSOCIATION.

As the time is approaching for the 29th annual meeting of the American Medical Association, certain questions pertaining to its general management, and bearing more or less upon its present and future influence, may properly invite attention. And one of these questions relates to the mode of electing officers, and especially the President. No one can doubt that much of the reputation, both at home and abroad, of this Association must depend upon the character of its presiding officers. It is, in one point of view, of less consequence whether he is from the North or the South, the East or the West; whether he sympathized with or against the rebellion; whether he is a man of fine presence, and popular in a social sense; nor even whether he is acquainted with parliamentary rules and would make the best presiding officer under a call for the "previous question"—in our opinion, all these considerations are of less consequence than that he should be a representative man in his profession; that is to say, a man known to all by his labors, and acknowledged by a majority of his contemporaries to be deserving of the highest honor. He ought to be a man who would do more honor to the Association than the Association could do to him.

It is a little singular, perhaps, that in this eminently democratic

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country, in which, theoretically, the people rule, no method has yet been devised by either politicians or statesmen which will prevent the nominations and appointments from being controlled in most cases by the "ring," the "caucus," or the "boss." Equally difficult has it been found to prevent this kind of centralization and limitation of power in medical societies, and the fault has been, so far as the American Medical Association is concerned, that every now and then, to say the least, a gentleman has been chosen to this office who was in no sense a representative of the profession, nor in any proper sense its deliberate choice.

The provision made for the election of all the officers, including the officers of the several sections and the standing committees, is as follows :—

"They shall be nominated by a special committee of one member from each State represented at the meeting, and shall be elected by vote on a general ticket."

Nothing could seem more fair, and in a strictly Arcadian state of society, the working of this system would probably be all that might be desired ; but it is quite certain that the human mind, in the course of its development to its present condition, has wrought out many inventions, and not the least of these is evasion of the force and intention of law. Thus it happens that, on the 2d day, when the President suddenly announces to members that there will be a recess of half an hour, in order that the members from each State may hold a private caucus, and select, each State for itself, one gentleman for the "nominating committee," the members gather, as well as they can, in little groups, or in two or three private rooms ; most of the time, on the part of a majority of the members, being occupied in finding the place of meeting. When found, the member has, perhaps, already been appointed, and the delegates are ready to report. If they had found the place of meeting earlier, they would have noticed that one gentleman—of pleasing address—took charge of the small, brief and harmonious caucus, nominating the chairman, secretary and the member of the committee, and that at his suggestion the member was placed under no restrictions as to the names he might select for officers. This would evidently be improper, as it would be construed into an attempt to anticipate and control the action of the nominating committee. The gentleman must not be embarrassed by "instructions."

It was fortunate that the gentleman of pleasing address knew where the caucus was held, and was there in time, as it was apparent that no one else knew exactly what was to be done, or who was the best man to be put upon the committee, and the delegates might have embarrassed him by suggesting their own favorite candidates.

It will be seen that it would be easy, if one were disposed to do so, for an aspirant for office, or for his friends, to manipulate a majority of the caucus meetings, and we have reason to know that it is often, and sometimes successfully, done.

Can this be prevented ? or, can the efforts of a certain class of office-seekers be, in any manner, rendered less effective ? We think it can, and that, too, without changing the By-laws or Constitution,

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and without the delays and commotion usually incident to an election without caucus nominations, and which the caucus system is wisely intended to obviate.

There is nothing in the laws of the Society to forbid the President asking for open nominations in the general meeting. These would not control the nominations by the committee, but might come as suggestions as to the prevailing wishes of the members. The members should then have instructions to meet at the close of the session then in progress, and the place of meeting of each State should be indicated. The member of the "nominating committee" being chosen, the chairman should invite opinions, and the delegates should be given to understand that they can "instruct" the member as to how to cast the vote of that State, at least within certain limitations, if they choose to do so.

Beyond this, nothing can be done, perhaps, at present, to remedy a notoriously growing evil, except for the Association to reject the nominations in whole or in part, whenever they are unsatisfactory, and especially to refuse to accept of those candidates who are known to have been laying pipe for several successive years, and which will, no doubt, be completed to Buffalo by the 4th of June.

LECTURES.

CLINICAL LECTURE ON THE HÆMORRHAGIC DIATHESIS.

Delivered in Bellevue Hospital, New York.

BY

JOHN T. DARBY, M. D.

Professor of Surgery in the University Medical College, N. Y.

[Reported for THE HOSPITAL GAZETTE.]

GENTLEMEN:—I have brought this boy before you to-day, as an illustration of what is commonly known as the hæmorrhagic diathesis. Although you read about this condition in your text-books, it is very seldom that we have an opportunity of exhibiting a case of the kind in the clinic, as it only occurs rarely. If you look at the pallid face, the bloodless lips, the tongue equally so, and the general tremulousness, you see at once that there is a condition of profound anæmia. There is a lack, or deficiency, in the quality of the patient's blood, though the quality of that fluid may be normal. The watery materials are quite abundant, and are even in excess; but the vital fluid is deficient in its nutritive elements, and, consequently, we have a defect in the coloring materials, giving rise to the peculiar pale and colorless appearance of the external surface of the body.

If, however, there were nothing present in the case besides this, we could not say that there was anything but simple anæmia; which, as

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you know, might arise from a variety of other causes besides the hæmorrhagic diathesis. Malaria is such a cause, and might give rise to a similar appearance. He also has the appearance of what is commonly known as a "*dirt-eater*," which is a defective condition originating in the improper digestion and assimilation of food. In this condition the individual, though he may eat a large quantity of food, does not seem to derive any benefit from it; it is not assimilated, and an impoverished condition of blood is the result. Such patients are said to be "*dirt-eaters.*"

We must look farther, then, than the mere appearance, and enquire into the history; and, in the present instance, we find the peculiar appearance to be due to the hæmorrhagic diathesis.

Here, on the outer aspect of the leg, near the knee, is situated a small wound of the skin. You observe that it is not located near any large vessel, either arterial or venous, and yet, after this slight injury, the patient bled rather copiously and continuously for two weeks. After the extraction of a tooth, the gum continued to bleed for more than four days, notwithstanding the patient and persistent use of every kind of styptic remedy; the bleeding was finally controlled by the application of a solution of the perchloride of iron.

In almost all of these cases you will generally find that some of the relatives of the patient have suffered from a similar condition, and usually it exists on the maternal side. One of the most frequent predisposing causes of the diathesis is an hereditary taint.

The immediate cause of the hæmorrhages is, either a want of proper innervation of the blood vessels, or a lack of proper contractility in the muscular walls themselves. This is the only reason which has yet been given to satisfactorily explain these cases.

In an experience of eighteen years I do not remember of ever having seen but one similar case. That was about six or seven years ago. The patient bled continuously from the nose for six or seven weeks, and then finally died. Every effort was made to save him, but it was all in vain. He received the best and most nourishing food in ample quantities and was treated with every known styptic. He received ergot internally, and many other medicines too numerous to mention, but nothing succeeded in stopping the hæmorrhage, and he finally succumbed. In that case the diathesis was transmitted directly through four generations, and this shows what a powerful factor hereditary predisposition is in the production of the disease. This unfortunate child exhibited in a marked degree, what Niemeyer describes as characteristic in some cases of the disease, viz.: a marked dilatation of the superficial veins. All the superficial veins were well marked, and you could follow their distribution down to the very small filaments from which they arose. They looked like streams with their tributaries, and the larger veins, such as the saphenous, the cephalic, the radial, and so on, could be followed with all their branches down to the terminal filaments. Each family or village of veins, as it were, was quite distinct, and it seemed like a geographical map. The same state was present on the chest and abdomen.

This condition is similar to what you observe when there is a tumor,

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pressing on some larger vessel, and the smaller veins that flow into it are distended with blood and their course becomes well marked on the surface. You often see the veins thus prominent in women with cancer of the breast. In cirrhosis of the liver, likewise, where the internal circulation is interfered with, the superficial vessels have to carry an increased amount of blood. In the hæmorrhagic diathesis the same condition exists, but it is not due to a similar cause, arising in these cases from an improper nerve supply to the blood vessels, or a want of proper contractility of their muscular fibres. The boy before us does not exhibit this peculiarity and in many cases there is no outward apparent characteristic of the disease, except, perhaps, the pallor and bloodless condition of the skin, which, however, as you are well aware may be due to many other causes.

Now what can be done as regards treatment? The boy is not old enough to take proper care of himself intelligently, and must be carefully watched by those around him to guard against accidents, wounds, injuries, etc., and even the slightest scratch of the skin, for no matter how small it might be, it might cause a hæmorrhage that would end in death. All those accidents must be prevented by himself and those around him, and the physician must prescribe remedies that will have the effect of improving the condition of the nervous system and of increasing the contractility of the vascular walls.

I would advise, in the first place, good nourishing food to build the body up and impart a certain amount of resistance to hæmorrhages, and also to enable him to withstand them more effectually if they do occur. At the same time some nervine is appropriate, one that will have a special tendency to affect the vaso motor system being preferable. Some preparation of strychnia, either the sulphate or the alkaloid itself will give tone to the nervous system. Ergot should also be used for its action on the muscular fibres themselves. Besides these measures he should have plenty of exercise and breathe good air, and general hygienic rules should be strictly adhered to.

I am glad, gentlemen, to be able to bring this case before you as it is a very rare one, and you might not have the opportunity of seeing one again for a long time.

CLINICAL LECTURE ON SECONDARY SYPHILIS AND BRIGHT'S DISEASE CURED BY JABORANDI.

Delivered at the Pennsylvania Hospital,
BY
J. M. DA COSTA, M.D.,
Professor of Practice of Medicine in Jefferson Medical School.

Reported for THE HOSPITAL GAZETTE.

I. SECONDARY SYPHILIS.

This woman was admitted to the hospital on the twenty-first day of February. She then had the usual symptoms of dysentery, viz.: blood in her passages, bearing down pains, and febrile excitement. Under active treatment the dysentery was quickly checked. Soon

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after this the patient's joints began to swell, and the unmistakable signs of articular rheumatism were ushered in. Under the belief that the case was one of true rheumatism, the regular treatment by the salicylates and salicylic acid was at once begun. Though the effect of these useful remedies was soon apparent, yet it did not seem to me that the case was much improved by their use, so I stopped them. As the woman was very weak, and, at the same time, feverish, I ordered her quinia and the acetates in large doses. The rheumatic symptoms slowly yielded; still there was a good deal of pain in the bones, and the patient did not seem to rally completely. Just as I was beginning to be very much perplexed as to the cause of this retarded convalescence, an eruption appeared on the face, and all doubt was at once dispelled. The eruption on the face was altogether typical. The same eruption appeared over various parts of the body—on the hands, chest, etc. Though this eruption was papular, yet the papules were small. In other parts it rather resembled maculæ. There has been but a very small amount of desquamation, and no itching.

I bring the woman before you this morning so that you all may take a good look at her, and so carry away in your minds the appearances of a very typical case of early secondary syphilis.

Though this is not in any way an unusual example of the disease, there are yet a few side questions which I wish to discuss with you before letting the case go. First, then, as regards the early symptoms of dysentery. What were they due to? I cannot give you a conclusive answer to this question. They may have been syphilitic manifestations; and yet I must candidly say to you that affections of mucous membrane are not generally the result of syphilitic poisoning. I think that we must look upon the dysentery as rather a coincidence than a symptom of specific disease.

Secondly, as regards the curious, irregular, ill-defined rheumatic attacks. Why was the treatment by salicylic acid and the salicylates of so little avail? Evidently, because the articular rheumatism was of syphilitic origin. The unyielding pains and persistent joint affection were uninfluenced by our treatment because they were due to syphilitic infection. Syphilitic rheumatism is not likely to be much affected by salicylic acid.

As soon as the dysenteric and rheumatic symptoms had passed away and the eruption had appeared, clearing away all doubt as to the true nature of the case, the patient was at once placed on an anti-syphilitic treatment—twenty grains of the iodide of potassium three or four times daily. I gave this drug, not because I thought it the best treatment for the specific disease as it appeared in this woman, but because I thought that the pains in the bones and the other rheumatic symptoms demanded it; and I was right in this belief, for the joint pains rapidly began to pass away. Just as soon as I was satisfied of the disappearance of these symptoms, I exchanged the iodide of potassium for a mercurial treatment, which is much better than the iodide in the early stages of this affection. I gave corrosive sublimate in doses at first of one twenty-fourth (1-24) of a grain, thrice

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daily. Later I doubled this amount so that the patient took 1-24th of a grain every three hours, making the whole amount ingested during the day equivalent to one-quarter of a grain of the bichloride. This was received without the production of any symptoms of poisoning. So much for the medicines employed. We shall give the patient plain food and keep her in bed until all the bone pains are gone.

ACUTE BRIGHT'S DISEASE CURED BY JABORANDI.

A. W., æt 55, single. Admitted on March 20th. Has never suffered from rheumatism, and has never had any specific disease. Has always been regular in her courses. The patient states, most positively, that she has been perfectly well all winter, and that her illness only began one week prior to her admission. She then noticed that being exposed to the vicissitudes of the weather, her feet and then her face began to swell. Finally, a general anasarca came on. She had, at the same time, some loss of appetite, with gastric pain and cough. When she was admitted to the hospital, her whole body was greatly swollen, and she was somewhat feverish; the temperature in the mouth being 99°. The heart was beating feebly, or rather the sounds of the heart were feeble. She complained of pain and weight in the pit of her stomach, and of considerable dyspnœa. She passed but little urine. There was no heart murmur to be heard, although we made a very careful examination of that organ. The tongue was clear, and the digestive disturbance not much marked.

What was the cause of the dropsy? A clue was at once afforded us by an examination of the urine, which was found to contain an enormous amount of albumen; the albumen, when precipitated, filling at least one-third of the test-tube. The microscope taught us that the urine also contained blood corpuscles, epithelial and hyaline casts and a few oil drops. Most of the casts were, however, epithelial.

I at once diagnosticated the case as one of acute Bright's disease—Bright's disease complicating acute renal dropsy. All this was self-evident. Only one doubtful point remained to be cleared up. Was, or was there not, prior organic disease of the kidneys? This was at first hard to determine off-hand. We had to wait until the acute attack had passed away under the proper treatment. The presence of casts and blood corpuscles in the urine seemed to answer the question in the affirmative at that time.

To-day we have the best of reasons for concluding that no disease of the kidneys pre-existed. The case has ended in perfect recovery. The abnormal constituents of the urine have almost entirely disappeared. This case has been an extraordinary one, on account of the patient's very rapid recovery.

And now you will, of course, want to know what our treatment has been. How we have brought it about that in the course of two weeks after her admission the patient is entirely recovered. The general dropsy, albumen in her urine, and dyspnoea all gone together. I ascribe all my success in the treatment of this case to the free use of jaborandi. Five days after the jaborandi treatment was begun, the whole face of the case was changed. The dose I ordered was one

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drachm of the fluid extract of jaborandi thrice daily. This dose produced excessive diuresis and diaphoresis. I am convinced that in jaborandi we possess a most valuable agent for combating the dropsical complications of Bright's disease. It should be given either in the form of the infusion, or the fluid extract. In cases where uræmic poisoning is a factor, and where the drug is consequently not well borne by the stomach, I have administered jaborandi by injecting it into the bowel. Though the effects of the drug when injected were not so striking as in the present case, I yet see no reason why it should not be given by the bowel as well as by the mouth. I have also tried the drug hypodermically, but I prefer not to speak positively at present of its effects when so used. In one instance I will say that it did produce considerable irritation of the skin.

How are we treating this woman, now that the dropsy has all gone? She is taking dialyzed iron internally and hypodermically. This treatment is improving vastly her general health and nutrition.

The origin of the disease in the present case is a very common one. It was brought on by cold and exposure. In children, acute Bright's disease generally follows scarlet fever. In adults it usually comes on immediately after exposure to dampness and vicissitudes of weather.

ORIGINAL ARTICLES.

SUB-LINGUAL PHLEGMON.

BY

EDWARD J. BERMINGHAM, M. D. NEW YORK.

Surgeon to the Good Samaritan Hospital, and to the Out-Patient Department of Bellevue Hospital, and Physician to the Chapin Home, Etc.

On Thursday, March 1st. 1877, I was called to see Mrs. L. a rather corpulent woman 53 years of age, married, and the mother of 7 children, all living and healthy. Mrs. L. had always enjoyed the best of health until about six weeks previous to this date, when she began to suffer considerably from a pain near the right ear; this was relieved in about a week or ten days by a copious discharge of pus from the external auditory meatus, which has continued more or less to the present time.

She now complains of a pain just below the angle of the jaw on the right side, which extends somewhat in the neighborhood of the ear. It causes considerable annoyance and prevents sleep and deglutition. Ordered cathartic, anodyne pill, and poultice.

The following day the pain and inconvenience had increased, and the throat felt sorer. An examination revealed no swelling externally, no pharyngitis or tonsillitis, but there was some stomatitis and the tongue was slightly enlarged and pushed up; deglutition extremely painful. Ordered poultices to be continued, and a mixture of pulv. chlorat. potas. in honey to be taken into mouth frequently.

The next morning (Saturday) the tongue had enlarged to such an extent that I requested a consultation, and accordingly Dr. J. L.

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Little was called. We concluded to make an incision within the mouth, beneath the tongue, and the bistoury inserted to the depth of half an inch, gave a negative result, and we concluded to await further developments. On Sunday morning the tongue had become displaced to such an extent as to obliterate the cavity of the mouth by having been forced upwards and backwards, and respiration was effected with the greatest difficulty. The patient had slept none for the past two nights, as every attempt to seek the recumbent position brought on suffocative attacks. She suffered terribly from thirst, but was unable to take a drop of liquid into the mouth to quench it. In fact, her sufferings were intense, and it was evident that she could not long survive in her present condition. Thinking that possibly I might find a depot of pus I passed an exploring needle beneath the tongue downwards and backwards and also downwards, but with no satisfactory result. Dr. H. B. Sands saw the patient in consultation later in the day. He renewed the explorations with the trocar, but with no better result. We concluded that tracheotomy might become necessary, but that for the present nothing more was to be done—Nourishment by the rectum.

The following morning I was called at an early hour to see the case, the patient was unable to assume any position except sitting, with the head bent forwards. She was taking long deep inspirations, giving evidence of the small space admitting air, and was becoming cyanosed. She had had no rest and was almost completely exhausted. Upon attempting to raise the head or recline the body, the enlarged tongue gravitated to the posterior wall of the pharynx and produced a violent suffocative attack. The case demanded urgent measures and accordingly I sent immediately for Drs. J. L. Little and F. A. Lyons, who resided in the neighborhood. A large sized aspirating trocar was passed in various dirctions into the enlarged mass beneath the tongue, both from the cavity of the mouth, and through the integument up behind the symphysis mentis, but without encountering any depot of pus. After further consultation and acquainting the family with her condition, (of which indeed they seemed to be fully aware) and of the dangers of operative interference, we decided upon tracheotomy, as the only means of prolonging life.

We selected chloroform as the anæsthetic, as it would give rise to little or no struggling. It had to be administered with the patient sitting and the head inclined forwards. When placed on the operating table it was evident that she was rapidly sinking, and before she could be completely anæsthetized, she became deeply cyanosed and expired. I immediately cut into the trachea, inserted a tube, and endeavored to resuscitate the patient by artificial respiration, but without avail.

This case is interesting on account of the extreme rarity of the affection. Drs. Sands and Little, in their large surgical experience, never having encountered a similar case, and I have been unable to find any on record. As regards operative interference, I think that if thorough exploration with a small trocar does not reveal the situation of a collection or collections of pus, in time to evacuate

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such depots before the patient becomes exhausted, that tracheotomy is demanded. This, in connection with rectal alimentation, will undoubtedly give us an opportunity to treat the affection as an ordinary phlegmon in any other situation, without any danger of the patient becoming exhausted from want of nourishment and oxygen.

HOSPITAL RECORDS.

PRESBYTERIAN HOSPITAL, NEW YORK.

Reported by ALBERTO LACAYO, M.D.

LIGATION OF BOTH LINGUAL ARTERIES, PRELIMINARY TO EXCISION OF RIGHT LATERAL HALF OF TONGUE.—SERVICE OF DR. LEWIS A. STIMSON.

Operation on Right Side.—Patient being well under ether, Dr. S. made a curved incision three inches long, concavity upwards, its centre 1-4 inch above lesser cornu of hyoid bone. The submaxillary gland was exposed, its sheath opened freely, and the gland, which was much enlarged, raised. The bellies of the digastric muscle were exposed and the hypoglossal nerve sought for between them, and behind the posterior border of the mylo-hyoid muscle.

The fascia covering the hyoglossus was much thickened, but after dividing it in the general direction of the external incision and pressing back its upper portion, the hypoglossal nerve and lingual vein were exposed. As the vein was large and lay near the pulley of the digastric, it was divided between two ligatures. The fibres of the hypoglossus were then picked up with a pair of forceps and divided for about 1-4 of an inch, the lingual artery found below it. A laterally curved aneurism needle armed with a cat-gut ligature was passed from below upwards, and the artery tied just above the point where a large branch, supposed to be the dorsal branch, was given off. Both ends of the ligature were cut short. A drainage tube was inserted in the wound, the edges of which were brought together by silk sutures. (It was done in 40 minutes.)

Operation on Left Side.—The operation on this side was essentially the same as that on the right side, the only difference being that the left lingual was exposed more readily, as the submaxillary gland was much smaller, the fascia below it not so dense, and it was not necessary to tie the lingual vein, (Occupied 20 minutes.)

Removal of Tongue.—The tongue was so firmly bound to the floor of the mouth that it could not be drawn out. The tip was seized with a pair of forceps; the whole organ was liberated from the floor, drawn forward, divided with scissors along the median line to within half an inch of the epiglottis and then across to its edge. There was no bleeding whatever.

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COLORED HOSPITAL, NEW YORK.

Reported by FRANCIS HUBER, M.D.

CEREBELLAR HEMORRHAGE.—SERVICE OF DR. S. WHITALL.

E. F., 46—M.—Black.—N. Y.—Admitted Aug. 17, '77. On admission, patient was fairly nourished. She presented the appearance of one suffering from some chronic cerebral affection. From a friend who called some time after the death of the patient, it was ascertained that she had been complaining of "neuralgia" of head for four or five years. She also had "fits" at times, which a doctor called epilepsy. Her relations (how closely related not known) were some of them "asthmatic" and some had "*phthisic.*"

The right side of face was paralysed. No loss of motor power was observed in the upper extremities. In walking, she would drag the right foot. With the exception of "headache," she did not complain of anything special.

The patient was rather quiet, and somewhat apathetic. When addressed, she would answer rationally, though in a hesitating and sluggish manner. In the examination, the most prominent subjective symptoms developed were dyspnœa, (present even when patient was quiet), a peculiar stridulous character to the breathing, and husky voice. A careful physical examination failed to reveal either cardiac or pulmonary disease. Search for aneurism or intra-thoracic tumor resulted negatively. Up to the date of her death, her condition was not materially changed. On the morning of the 20th she was found under the bed unconscious and breathing stertorously. The body was rigid, with the head thrown back; eyes were widely open and staring. After being put to bed, she seemed to regain consciousness to a slight extent, for she rolled over on right side, and with one hand pointed under the bed, with the other signified that she desired to vomit. When a vessel was brought, she acted as though nauseated, but did not vomit. A few moments after, death occurred. Urine, amber, acid, 1012, non-albuminous.

Autopsy, 10 hrs. P. M.; body fairly nourished; rigor mortis marked.

Brain.—The pia mater at the base and convexity was found to be thickened and opaque. In the Sylvian fissures chronic adhesions were discovered. At the base, underneath the pia mater covering the medulla, cerebellum and pons, a large amount of clotted blood was found. The arteries at the base were intact. The inferior cerebellar artery of right side was thickened, translucent, readily torn, and at one place (in cerebellar portion) an apparent dilatation existed, but upon slitting up the artery this proved to be a morbid growth originating in its walls. A very distinct prominence was observed in the right lobe of the cerebellum. An incision into this exposed a mass of clotted blood nearly as large as a hen's egg. On close investigation, it was found that the blood had probably escaped from the right inferior cerebellar artery, after it entered the brain tissue.

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On the attached surface of the artery, a rupture was discovered. Whether ante or post mortem, could not be determined positively, as the vessel was so very friable. The medulla softer than usual, did not contain any extravasated blood. The 3d and 4th ventricles with the intervening canal were partly filled with coagula.

Lungs.—Seat of hypostatic congestion, otherwise normal.

Heart.—No pathological changes present. In the aortic coats numerous calcareous plates were perceived.

Several calcareous glands existed at the root of the left lung. One was situated just at the point where the left recurrent laryngeal nerve is given off from the par vagum. The latter, at the origin of the former, was flattened out, and so intimately connected with the calcareous bronchial gland, that a separation was not possible.

An examination of the larynx revealed neither ulcerations, new growths, nor inflammatory changes, to explain the laryngeal symptoms; a little tough mucus only was discovered.

Liver.—Upon its surface numerous depressed cicatrices (remains of specific peri-hepatitis) existed. The capsule was considerably thickened and opaque; organ otherwise healthy.

Spleen and kidneys normal.

Microscopy.—The growth upon the cerebellar artery was found to be a gumma—consisting largely of small round nucleated granular cells, spindle and club-shaped cells in connective tissue. No alveolar arrangement detected. An examination of the artery revealed a similar infiltration of cells between the middle and inner coats, while the outer coat contained an abundance of amyloid material, but no cellular formations.

PERISCOPE.

COLLABORATORS.

Dermatology:
HENRY G. PIFFARD, M.D.
Diseases of the Nervous System:
EDWARD C. SEGUIN, M.D.
Diseases of Women and Children:
FRANK P. FOSTER, M.D.
General Surgery:
EDWARD J. BERMINGHAM, M.D.
Genito-Urinary Disease and Syphilis:
ROBERT W. TAYLOR, M.D.
Materia Medica and Therapeutics:
FREDERICK A. LYONS, M.D.
Ophthalmology and Otology:
SAMUEL B. ST. JOHN, M.D.
Orthopedic Surgery:
NEWTON M. SHAFFER, M.D.
Practical Medicine:
E. DARWIN HUDSON, JR., M.D.

THE VALUE OF EXTENSION IN THE TREATMENT OF FRACTURES OF THE FEMUR.

This is a clear and full exposition of the author's views of the proper treatment of these fractures. Dr. Hodgen maintains in common with a vast majority of practical surgeons, that continuous and equable extension is indispensable to the best results. He does not believe that the plaster-of-Paris dressing can possibly make continuous extension; neither when the patient is kept constantly in bed,

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nor when he is permitted to be up and upon his crutches a portion of the time "The proposition is too absurd," he remarks "to deserve serious consideration." Dr. Hodgen does not think the proper extension can be accomplished except with the limb in the flexed position, and suspended so as to avoid the unequal resistance of friction.

Dr. Hodgen's arguments are specious, but they are not entitled to so much weight as they would have been had the facts been carefully gathered and arranged, and presented to the public. Certainly with his large experience and habits of accurate observation, this ought not to be difficult. Thus far the latest and most trustworthy statistics show conclusively that as between Buck's extension and plaster- of-Paris, the former gives the best results, in every point of view. It remains to institute similar comparisons between Buck's extension and Dr. Hodgen's suspension.—*J. T. Hodgen in St. Louis Med. and Surg. Jour. April*, 1878.

DIAGNOSIS OF SCIATIC DISLOCATIONS OF THE HIP.

The writer calls attention to the fact that Dr. O. H. Allis, of Philadelphia, first gave to the public an account of the "New Sign" in the *Phila. Med. Times*, for March 28, 1874. Thus antioipating Dr. Dawson of Cincinnati by several years.—*Amer. Jour. Med. Sci. April* 1878, *p.* 584. [Dr. Dawson's paper was published in the number of this journal for Jan. 1, 1878.]

SUB-CORACOID DISLOCATION OF THE HUMERUS, BY MUSCULAR CONTRACTION.

A Case.—*Amer. Jour. Med. Sci. April*, 1878. *From Rivista Clinica dc Bologna, Jan. 10*, 1877.

BACKWARD DISLOCATION OF THE HEAD OF THE HUMERUS.

Supposed to have occurred from muscular action. Reduced on the 29th day, by P. S. Connor, M. D., Prof. Anat. and Clinical Surgery, Med. Col. of Ohio.—*Amer. Jour. Med. Sci., April*, 1878, (*p.* 451.)

NEWS ITEMS AND NOTES.

American Medical Association.—The Twenty-ninth Annual Session will be held in the city of Buffalo, N. Y., on Tuesday, Wednesday, Thursday and Friday, June 4, 5, 6 and 7, 1878, commencing on Tuesday at 11 A. M.

"The delegates shall receive their appointment from permanently organized State Medical Societies, and such County and District Medical Societies as are recognized by *representation in*

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their respective State Societies, and from the Medical Department of the Army and Navy of the United States."

"Each State, County and District Medical Society entitled to representation shall have the privilege of sending to the Association one delegate for every ten of its regular resident members, and one for every additional fraction of more than one-half that number: *Provided*, however, that the number of delegates for any particular State, territory, county, city or town shall not exceed the ratio of one in ten of the resident physicians who may have signed the Code of Ethics of the Association."

☞ Secretaries of Medical Societies as above designated are earnestly requested to forward, *at once*, lists of their delegates.

Will you kindly send to the Secretary a list of your members with their residences, in order that a correct record may be made of all who are in affiliation with this body?

SECTIONS.

"The Chairmen of the several sections shall prepare and read in the general sessions of the Association, papers on the advances and discoveries of the past year in the branches of science included in their respective sections. * * *"—BY-LAWS, Art. II., Sect. 4.

Practice of Medicine, Materia Medica and Physiology:
Dr. A. L. LOOMIS, New York, *Chairman.*
Dr. J. H. ETHERIDGE, Chicago, Ill., *Secretary.*

Committee appointed to report to this Section:
On Clinical and Meteorological Records:
Dr. N. S. DAVIS, Illinois, *Chairman.*

Obstetrics and Diseases of Women and Children:
Dr. E. W. JENKS, Detroit, Mich., *Chairman.*
Dr. H. O. MARCY, Cambridge, Mass., *Secretary.*

Surgery and Anatomy:
Dr. HENRY H. SMITH, Philadelphia, Pa., *Chairman.*
Dr. E. T. EASLEY, Little Rock, Ark., *Secretary.*

Medical Jurisprudence, Chemistry and Psychology:
Dr. WALTER KEMPSTER, Oshkosh, Wis., *Chairman.*
Dr. E. A. HILDRETH, Wheeling, W. Va., *Secretary.*

State Medicine and Public Hygiene:
Dr. J. L. CABELL, University of Va., *Chairman.*
Dr. E. J. MARSH, Paterson, N. J., *Secretary.*

The following Committees are expected to report:—
On Prize Essays:
Dr. E. M. MOORE, Buffalo, N. Y., *Chairman.*
On Necrology:
Dr. J. M. TONER, Washington, D. C., *Chairman.*
On Catalogue of National Library:
Dr. H. C. WOOD, Pa., *Chairman.*
On Recommendations in President Bowditch's Address:
Dr. N. S. DAVIS, Illinois, *Chairman.*

To be acted upon:—

Changes in By-Laws, proposed by Committee on Nominations in 1877.

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"Under Art. II., Sections, 10th line from top, the word *Essayist* shall be introduced immediately after the word 'Chairman,' so as to read as follows: 'The Chairman, Essayist and Secretary of the several sections shall, like other officers of the Association, be nominated, etc.'"

Same Article, line 22d *et seq.*, to read as follows: "The Chairmen of the several Sections shall preside at the meetings of their respective Sections. The Essayists shall prepare and read in the general sessions of the Association papers on some subject to be selected by themselves, but relating to one or more of the branches of science included in their respective Sections; the reading of such papers not to occupy longer than forty minutes for each."

Amendment proposed by Dr. S. C. BUSEY:—

Plan for Organization of the American Medical Association.

The general meetings of the Association shall be restricted to the morning sessions; and the afternoon sessions, commencing at three o'clock, shall be devoted to the hearing of reports and papers, and their consideration, in the following Sections:—

1. Practical Medicine, Materia Medica and Physiology.
2. Obstetrics and Diseases of Women and Children.
3. Surgery and Anatomy.
4. Medical Jurisprudence, Chemistry and Psychology.
5. State Medicine and Public Hygiene.

The Sections shall be organized by selecting from the permanent membership such members as may have acquired distinction in the branches of medical science assigned to the respective Sections, such selections to be made from the roster of permanent membership next preceding the adoption of this amendment, by a committee consisting of the chairman and so many of the ex-chairmen of the respective Sections for the three years next preceding as may be present at the time of the adoption of this amendment; provided, however, that no one shall be thus made a member of more than one section.

Only permanent members shall be eligible to membership of the Sections; and annually, as hereinafter provided, each Section may elect such as may be qualified by three years' consecutive membership, and who may have acquired distinction in the branches assigned to the Section. Forfeiture of permanent membership shall forfeit membership of Sections, but such forfeiture shall not prevent a re-election.

The officers of the Section shall consist of a Chairman, Secretary, a Committee on Business, a Committee on Membership, and a Committee on Essays. The Chairman and Secretary shall be elected by a majority of the ballots cast by the members of the Section, and shall hold their offices until the close of the business of the annual meeting next succeeding their election. The committees shall be appointed by the Chairman, and hold office for one year, or until their successors are appointed.

The Chairman shall preside at all the meetings of the Section, perform all the duties ordinarily pertaining to the duties of a presiding

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officer; shall exercise general supervision over the business of the Section; see that the duties of the officers and committees are properly discharged, and shall prepare and read, in general sessions of the Association, a paper on the advances and discoveries of the past year in the branches included in the Section; the reading of such paper shall not occupy more than forty minutes.

It shall be the duty of the Secretary to keep a correct record of the proceedings of the Section, and report the same to the Permanent Secretary; to revise and correct the reports of the stenographer, and deliver the same to the Committee on Essays; and to perform such other duties as may properly appertain to the office of Secretary.

The Committee on Business of each Section shall consist of three members, to be selected, when practicable, from the members residing in or near the city in which the meeting of the Association is to be held.

It shall be the duty of this Committee to prepare business for the Section, and, with that in view, to select two or more subjects appropriate to the Section, and also to appoint from the members of the Section as many members, to each of whom a subject shall be assigned for report thereon, which report shall be prepared and submitted to the Section at the meeting next ensuing. Voluntary papers may, with the approbation of the Committee, be submitted by any member of, or delegate to, the Association. All papers and reports must be sent to the Committee at least one month before the meeting, and it shall be the duty of the Committee, after careful examination, to fix the time and order of presentation, and to prepare a memorandum of the titles, together with the main points set forth in the argument, which shall be printed and distributed to the members of the Sections by the Assistant Secretary.

The Committee on Membership of each Section shall consist of five members. It shall be the duty of this Committee annually to examine the roster of permanent membership, and recommend for election to membership of the respective Sections such as may be eligible and deemed qualified. It shall also examine the roster of membership of the Section, make all necessary corrections of names and addresses, erase from the list the names of all who may have forfeited their membership, and designate the deceased members.

The Committee on Essays shall be composed of three members. To this Committee shall be referred for examination all papers read before the Section, and all debates. The Committee will be allowed thirty days, at the expiration of which time it shall forward the papers to the Committee on Publication, with such recommendation as may be deemed proper; but no paper or discussion, either in whole or in part, shall be published in the Transactions without the recommendation in writing of said Committee on Essays.

The Committee of Arrangements shall provide for each Section a competent stenographer, who shall furnish the Secretary with a full verbatim report of the debates of the Section.

No member shall address the Section more than once upon the same subject, nor speak longer than fifteen minutes without unanimous consent.

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The Permanent Secretary shall prepare annually a list of the members of each section, which shall be published in the Transactions, and shall furnish each delegate with a printed plan of organization and by-laws, together with rosters of the permanent and Section membership.

Amendment proposed by Dr. T. D. FITCH:—

"Plan of Organization, Sect. II., paragraph referring to permanent members. Strike out 'and of such other members as may receive the appointment by unanimous vote, they shall continue such so long as they remain in good standing, etc.'"

Amendments proposed by Dr. N. S. DAVIS:—

"Strike out from By-laws the whole of fifth paragraph, Sect. II., 'Papers appropriate to the several Sections, in order to secure consideration and action, must be sent to the Secretary of the appropriate Section at least one month before the meeting which is to act upon them. It shall be the duty of the Secretary to whom such papers are sent, to examine them with care, and, with the advice of the Chairman of his Section, to determine the time and order of their presentation, and give due notice of the same; and, after their full examination and discussion by the Section, they shall be sent to the Permanent Secretary of the Association.'"

Strike out all of third paragraph, Section VIII., "It shall be the duty of every member of this Association, who learns that any existing medical school departs from the published conditions of graduation, to report the fact at the annual meetings; and, on proof of the fact, such school shall be deprived of its representation in this body."

Strike out all of second paragraph, Section IX., "This Association recognizes as a 'regularly organized' medical college one that has been represented at any meeting, and that complies with the rules and directions found in the published *Transactions*, vol. xiii. page 33."

Amendment offered by Dr. X. C. SCOTT, and others:—

"Add to the five existing Sections a Section for Ophthalmology, Otology, Laryngology, which shall be known and designated as Section 6."

It is probable that several railroads will carry delegates to Buffalo and return for one and one-third fare. Such roads as agree so to do will be announced in the Journals.

Bronchine.—The famous "bronchine" is made from a prescription originally obtained by a member of the Union Club of this city, from his medical attendant, which is as follows:

℞

Mag. sulph.	ʒ ij
Spts. Mindereri,	ʒ vj
Syr. limon.	ʒ ij

M.

Sig. Dose, a tablespoonful.

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Treatment of Diphtheria.—During the past season a very malignant epidemic of diphtheria prevailed in a region of Rhode Island of which Little Comfort is the centre. It attacked all ages, and was very fatal, notwithstanding the conscientious trial of all the usual remedies. Dr. White, of Little Comfort, at length hit upon the following remedy, the success of which was, in almost every case, prompt and efficient.

Pulv.	cinchona,	2 parts.
"	capsici,	2 parts.
"	ipecac,	1 part.

M.

Sig. 5 to 10 grains every 2 hours.

Dr. W. subsequently made a tincture from the above powder, which was administered in doses of from 5 drops to a teaspoonful every two hours. Since last fall three barrels of this tincture have been sold.

Death of Prof. Francis G. Smith.—Dr. Francis Gurney Smith, Professor of the Institutes of Medicine in the University of Pennsylvania, died in his native city, Philadelphia, on April 13th, at the age of 60. Since his graduation in medicine in 1840, he has held a prominent place in the profession. He was one of the compilers of *Neill & Smith's Compendium of Medicine*, was editor of the *Phila. Med. Examiner* for nine years, and of the American editions of *Carpenter's* and *Marshall's* works on *Physiology*, and the translator of *Barth and Roger's Manual of Auscultation and Percussion.*

The Use of the Uvula.—Prof. Alfred H. Garrod, F.R.S., in a recent lecture, laid great stress upon the functions of the uvula, an organ present only in man and the anthropoid apes, and expressed his opinion that the uvula serves the purpose of preventing the food from entering the back part of the nose, if it should so happen that during the act of swallowing the individual should make a sudden effort at expiratory breathing. The uvula, being pressed back by the moving food against the posterior wall of the pharynx, would so retain a free communication between the mouth and the pharynx, at the same time that the nares are closed by the soft palate.—*Scientific American.*

Professional Secrets.—The profession of Philadelphia are endeavoring to effect the passage of the following bill:—"No person duly authorized to practice physic or surgery shall be allowed or compelled to disclose any information which he may have acquired in attending any patient in his professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for him as a surgeon."

Public Analysts.—The *Société d'Hygiene* of Paris is making arrangements to establish in the cities and towns of France chemical laboratories for the purpose of examining articles of food and detecting adulterations or unhealthful constituents.

American Microscopical Society.—At a recent meeting of this society, the following officers were elected for the ensuing year:—

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President, John B. Rich, M.D.; *Vice-President*, Wm. H. Atkinson, M.D.; *Secretary*, O. G. Mason; *Treasurer*, T. d'Oremieulx; *Curator*, John Frey.

Conclusive.—In an article on Amylidenamine Silver Nitrate, by W. G. Mixture, in the *American Journal of Science and Arts*, the author states that, "if the corresponding ammonio compound be regarded as diammonium-argentammonium nitrate, the derivative from valeralammonia may be regarded as di-amylidenammonium-argentamylidenammonium nitrate."

A New Vapor Bath.—Mr. Chas. Jansen, of this city, has invented a vapor bath adapted in shape to the entire body or any part, and constructed of outer closed and interior perforated walls, forming compartments to which steam is supplied by pipes.

Abuses of Medical Charities.—At the last monthly meeting of the Medical Society of the County of New York, Dr. George Mitchell read a report prepared by the Committee on the Abuses of Medical Charities. In this it was stated that in Philadelphia during 1876 one out of every five inhabitants was treated gratuitously at the dispensaries or Hospitals; in Boston during the same period one out of every four, and in this City also one out of every four. It was shown recently that only 12 out of 152 applicants for free treatment, whose cases were inquired into, were proper objects of charity. Excluding the institutions on Blackwell's Island there were, during 1876, it was said, 42 hospitals and dispensaries in this City, or almost two charitable medical institutions for each ward. The revenues of those institutions aggregated $720,561, and the number of patients treated was 251,544. Proof of the ability of the greater number of persons who apply for free treatment at the institutions to pay at least small fees, was shown to exist in the fact that of the entire number of persons who were vaccinated at the Eastern Dispensary in this City, in the months of May and June, in 1876 and 1877, only 38 per cent. returned to the institution at the end of eight days to show how the virus had acted. Each of the persons comprising the remainder of 62 per cent. forfeited the 50 cents paid at time of the vaccination. It was argued, therefore, that persons who can afford to lose 50 cents each through negligence could pay physicians a small fee for services. A preamble and resolutions were commended by the committee for adoption by the society. These declared that as the benefits of dispensary and hospital service are not restricted to paupers as they should be, members of the medical profession are deprived of business properly belonging to them, and hence some of them are suffering for lack of the necessaries of life. They next call upon the Legislature to enact laws to prevent persons receiving free medical attendance at institutions, who are able to pay for such aid. In conclusion they declare that hereafter members of the society shall not give gratuitous service in the charitable medical institutions except on pain of disfellowship. The preamble and resolutions were referred to the *Comitia Minora* of the society for further consideration.

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Good Samaritan Hospital.—At the last monthly meeting of the Board of Managers of this institution, the following by-law was rescinded:—

"No member of a family whose income is over ten dollars a week shall be entitled to gratuitous treatment. Those families whose income is between ten and fifteen dollars per week shall be required to pay ten cents per week while under treatment in the dispensary department. Where the income is over fifteen dollars, but does not exceed twenty dollars, they shall be required to pay twenty cents per week. Where the income exceeds twenty dollars per week, the rate per week shall be fixed at the discretion of the surgeon. All moneys received from this source shall be handed to the Treasurer at the end of each month."

In place of the above, the following substitution was made:—

"No member of a family whose income is over ten dollars a week shall be entitled to gratuitous treatment. Members of families whose income is between ten and fifteen dollars per week shall be required to pay twenty cents per week while under treatment in the out-patient department. Where the income exceeds fifteen dollars, the patients shall not be entitled to the benefits of the institution. All moneys received from this source shall be handed to the Treasurer at the end of each month."

In a future issue we shall give an account of the service in this institution, and the result of the practical application of the "Provident System."

Lectures:—We have completed arrangements for the publication of the following special courses of lectures, which will appear during the summer months:—

Two Lectures on Lister's Antiseptic Method of Treating Surgical Injuries; by James L. Little, M.D.

A Course of Lectures on Stricture of the Urethra and on Stone in the Bladder; by Robert F. Weir, M.D.

A Course of Lectures on Insanity; by Edward C. Seguin, M.D.

Other special courses will be announced later.

Prof. Agnew's Case of Lithotomy.—In the case reported in the last number of this journal, the patient, during the second week of convalescence, was seized with a very severe attack of peritonitis, which reduced him so greatly in strength that his system could not rally, and he died on the fourth day of the attack.

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THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY.

A WEEKLY JOURNAL OF MEDICINE, SURGERY AND THE COLLATERAL SCIENCES.

EDITED BY

EDWARD J. BERMINGHAM, M.D., and FREDERICK A. LYONS, M.D.
H. H. KANE, M.D., Associate Editor.

VOL. 3, NO. 12. NEW YORK, MAY 9TH, 1878. WHOLE NO. 32.

[The editors hold themselves in no way responsible for the views expressed by contributors.]

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EDITORIAL.

THE AMERICAN MEDICAL ASSOCIATION.—WHAT HAS IT ACCOMPLISHED?

It would be difficult to answer this question by any formal presentation of facts in evidence. If, during the existence of the American Medical Association, medical science has advanced in these states and the standard of medical education has improved, or the reverse has happened,—in either case it would be difficult to trace such results directly to the influence of this association, or perhaps to any other single source. The causes of progress or decay in medical science, as in politics or religion, are often inscrutible; but aided by the light of past experience in these and other matters, we may be entitled to form an opinion and to entertain a belief. In our opinion, then, it has accomplished much good. Every effort in the right direction is useful, even though the end attained is far short of the hope and intention of the one who makes the effort. The man who puts his hands to the lever gains muscle, and is a better man for it, if he does not appreciably move the weight; and a sufficient number of hands acting together is the lever of Archimedes, which, when it has found a fulcrum, is irresistible. This is our American mode of doing things—by the multiplication of hands. Power with us has no

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centralization. There is no one mind to conceive, nor one hand to execute reforms. The people think, plan and propose, and when they are ready to act, they come together in masses, and by their united strength accomplish what under other governments would have been left to the central and absolute power.

Thus it happens that in this country medical societies are formed for every department of medical science, for cities, and counties, and states, and combinations of states. Of these, the American Medical Association, having the greatest number of members, gathered from the widest range, both geographically and scientifically, must necessarily have the greatest accumulation of strength. From the beginning this association has demanded a higher standard of preliminary education for medical students, longer terms of study, longer courses of college and hospital instruction, a higher standard of attainment for the degree of doctor in medicine, and strict adherence to the established code of ethics. If all these things have not been attained, it is quite certain that the medical profession is more and more impressed with their importance and necessity. One after another the best and most respected medical colleges are yielding to the pressure of opinion and of events, and are falling into line with the advanced views of educated physicians.

We do not yet see the millenium of medical matters very near at hand. We are afraid we may have to wait for that; but we see plainly enough, progress in the right direction, and it is our confident belief that to the steady, persistent and healthful influence of this association, much of this progress may be properly ascribed.

NEW YORK COLLEGE OF VETERINARY SURGEONS.

In our issue for the 15th of March we had occasion to make an exposé of an institution known as the "New York College of Veterinary Surgeons," at which time we showed that it was entitled only to the condemnation of the profession, as several members of its Board of Trustees and Faculty were either engaged in advertising and dispensing proprietary and secret remedies and "cure-alls," or were using or allowing their names to be used in furthering the sale of these nostrums. We also censured a prominent and highly esteemed member of our own profession for recognizing the institution to such an extent as to deliver the valedictory address at their commencement.

In reply to our denunciation we have received a letter from "R. W. Finlay, V. S., Professor of Theory and Practice, New York College of Veterinary Surgeons," in which he makes the following corrections of the statements contained in our editorial of the 15th of March. He informs us that George W. Busteed is not the Medical Director of the college, but a Trustee, and that the names of the medical men which appear on a circular setting forth the many virtues of his "Superlative Cure" were placed there without their consent. Prof. Finlay acknowledges all our other charges to be true; viz., that Mr. Going, the representative man of the Faculty, is the proprietor of "Copeman's Tonic Powders" and "Going's Worm Destroyer," that

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he is engaged in corresponding openly and over his own name with horsemen in all parts of the country, through the pages of the *Spirit of the Times*, and that he advertises his nostrums. Also the connection of Mr. Busteed with the institution, with the modification noted above; and that the graduating class consisted of three, two of whom had failed in their examination three years before, when the college was under able and honorable management, the third being the brother of Prof. Going; and we have since learned that one of the two former gentlemen is Prof. Finlay's brother.

We have little more to say in regard to this matter. We are surprised that gentlemen should associate and identify themselves with an institution countenancing such unprofessional conduct and practices as we have called attention to. If the names of these gentlemen were put upon this "cure-all" circular without their knowledge, we would like them to inform the profession if they were made members of the faculty without their knowledge? Having been made members of the faculty of this institution, and having been subsequently made acquainted with the practices of its representatives, have their names been continued on its announcement without their knowledge? These are questions which we should be pleased to have these gentlemen answer; and we think that they not only owe it to themselves, but that they are obligated to that profession which has nurtured and honored them, not to bring disgrace upon it, but to resign their positions immediately. Dr. Hammond's offense is past, and we are charitable enough to believe that the dishonor which he brought upon the profession by acting as the orator of the evening upon the occasion of the graduation of three such distinguished gentlemen, was done thoughtlessly. We believe that he now sees his error and that it will be some time before he fails to thoroughly investigate any statements which may be made to him on any future occasion, when he may be called upon to appear before an audience as the representative of the medical profession, and in a position in which he may compromise its honor.

Prof. Finlay has asked us to correct the mistakes which were made in the issue for March 15. We have done so, by correcting Mr. Busteed's title, and by announcing that the names of the medical men appearing on the "Superlative Cure" circular were placed upon it without their consent, *and were allowed to remain on it without their command that they should be removed.* We have no reason to alter our convictions in regard to all parties concerned; indeed, time has but strengthened them.

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LECTURES.

TWO LECTURES ON LISTER'S ANTISEPTIC METHOD OF TREATING SURGICAL INJURIES.

Delivered at the College of Physicians and Surgeons, New York.

BY

JAMES L. LITTLE, M.D.

Lecturer on Operative Surgery and Surgical Dressings in the College of Physicians and Surgeons; New York. Professor of Surgery in the Medical Department of the University of Vermont. Etc.,

[Reported for THE HOSPITAL GAZETTE.]

LECTURE I.

GENTLEMEN:—We will turn our attention this morning to the subject of "Antiseptic Surgery" a topic, at present, of universal interest, and one with which, even should you never practice it, scientific medicine demands that you should be familiar.

Acknowledging its importance, then, we will at once pass to a consideration of the subject. Up to a comparatively recent date all the putrefactive changes taking place in organic substances were supposed to be produced by the oxygen of the atmosphere; the belief being based upon the fact that when the atmosphere was thoroughly excluded from the substance or substances in question, no putrefactive change occurred; and that such changes did take place soon after air was admitted or when it was not excluded.

Microscopic examinations, however, soon determined the fact that other substances were present in the broken down material, besides the products of decomposition. Minute living bodies, among which bacteria stand most prominent, were found to exist there in immense numbers. Whether the substance was solid or fluid these little bodies were found swarming through it, living and multiplying, and the question very naturally arose, how and where did they originate?

Bastian, on the one hand, advocated the theory of spontaneous generation, while others, including Tyndall, showed by various experiments that germs must have already existed in, or been introduced into the fluid or solid before the bacteria and their kindred could be produced; they springing from these germs when once the conditions for their production were favorable. To-day some of the greatest minds in Europe are engaged upon the subject; the scientific journals are filled with articles relating to it; and although the question is still unsettled, the practical application of some of the results of research and experiment has been successfully made in our department of medicine; viz.. Surgery.

Professor Lister, accepting the germ theory, has applied to the treatment of open wounds an entirely new method, which has so far yielded the most wonderful results. To-day, I wish to give you some details concerning it, and before doing so I should like to impress it

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thoroughly upon your minds, that in order to obtain results such as Lister's, it is absolutely necessary that nothing, however little, should be slurred over, and that the fullest and most careful attention should be paid to all details, both during and after the operation.

Accepting the "germ theory," then, we must believe that the atmosphere, everywhere about us, is filled with germs of various kinds, that, when the air is allowed free access to a wound, are very liable to settle upon and cling to it, and the resulting organisms to breed and multiply, almost *ad infinitum*, filling the fluids, pervading the solids, and producing changes that result in putrefaction. Knowing this then, it is very easy to understand that when the air containg such germs is thoroughly excluded from a wound, or when these germs are destroyed before reaching it, no such changes will take place. That degree of inflammation and suppuration which has hitherto been considered as the necessary result of such wounds will be entirely prevented, absorption of the products of decomposition not taking place traumatic fever does not show itself, nor indeed is there any rise in temperature.

Let us turn our attention for a few moments to the manner in which wounds heal.

There are two principal methods by which healing takes place. First, that which is called healing by adhesive inflammation. In these cases slight redness takes place around the wound; plastic lymph is poured out between the cut surfaces; there is a slight rise in temperature, and a small cicatrix is left after the wound is healed. This method surgeons generally call healing by "first intention." Second, healing by granulation or "second intention." By this, we mean those cases where, either from the edges being kept apart, or from some loss of tissue, primary union cannot take place. What results? Inflammation is set up around the wound, there is redness more or less marked, and a rise in temperature,—the so-called imflammatory or traumatic fever. The wound soon becomes covered with a thin pellicle of exudation, which rapidly goes on to the formation of pus. The pus once formed, the redness diminishes or disappears, the pain subsides, the temperature falls, and the discharge continues until the granulations rise up to a level with the edges of the wound, and cicatrization takes place.

I have purposely left out some of the methods of healing; the two that I have given you sufficing to illustrate what I have to say.

A wound, of whatever nature, treated strictly in accordance with the rules laid down by Mr. Lister, will heal without the appearance of any of the phenomena characteristic of union by the second intention, and under this treatment we no longer look for the "healthy, cream colored, laudable pus" of olden times. Indeed, that which we once considered normal, we now consider abnormal. I have performed a number of successful operations by this method. Recently I amputated the thigh of an old woman on account of malignant disease of the lower extremity. After the amputation the patient's temperature was accurately taken morning and night, and never, at any time during convalescence, did it rise higher than 99°, nor was

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there the slightest suppuration. The same result followed, recently, in an amputation at the knee joint. I have also had, lately, four successive cases of removal of the breast heal without the slightest redness around the wound, the formation of pus, or elevation of temperature. To be sure, breasts dressed in the old way would occasionally heal without suppuration, but, gentlemen, this was a rare occurrence in my experience,—partial union being the rule, with more or less suppuration. Lacerated wounds, compound fractures, have all done well under this treatment.

Lister's method, properly followed out, prevents inflammation and suppuration, and this is something entirely new. I think, gentlemen, that if these successes continue under Lister's method of treatment, that some of us will be obliged to restudy our surgical pathology.

With these preliminary remarks, I will now describe in detail the materials used in applying Lister's method. Of all substances used as germ destroyers, carbolic acid has, thus far, proved to be the most effectual. Other antiseptics have been tried, but the results do not equal those obtained with carbolic acid. Lister's method is essentially this: In treating an open wound, let neither the air, the instruments you use, your hands, nor the dressings that are to be applied, nor in fact anything, come in contact with the wound unless it has been thoroughly saturated or wet with a solution of carbolic acid, and, at the same time, keep the wound thoroughly drained.

Carbolic acid comes in crystals, but the addition of a little water dissolves them; and gives you a solution. This sample, which I show you, is known as Calvert's carbolic acid. When here in 1876, Mr. Lister said that he used the absolute phenol, which he thought had less odor, and was more soluble than carbolic acid, which, however, is less expensive, and answers equally well. You should procure two bottles; one that will hold a quart, and one that will hold two quarts; and a two ounce graduate. The quart bottle of course contains thirty-two ounces, and by pouring out two ounces of water, you have thirty left. To this quantity of water you add an ounce and a half of carbolic acid, and you have a solution of the strength of 1 part of carbolic acid to 20 of water. By filling the two quart bottle with water, pouring off four ounces, and adding the same amount of carbolic acid (℥ iss) you have a solution of the strength of 1 part of carbolic acid to 40 of water. If, however, you wish to keep but one solution on hand, let it be the 1 to 20, and by pouring a cupful of this into a basin and adding a cupful of clear water, you have the 1 to 40 solution, whenever you may wish to use it. I think it is better to keep both on hand. Now, you are ready for work, in so far as the solutions are concerned.

As to the *spray*, Mr. Lister insists that the immediate atmosphere must, during the operation, be thoroughly carbolized, and the germs that it contains thus destroyed. For this purpose you will use the 1 to 20 solution. The proper use of the 1–20 and 1–40 solutions is a matter of importance, and it may be well to dwell a little upon it. The 1–20 solution is used for puri-

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fying the parts upon which you are about to operate. They must be thoroughly washed off with soap and water, and afterwards cleansed with the solution. The hands of the surgeon and his assistants should be thoroughly cleansed, the finger nails being well cleaned by the use of a nail brush, and afterwards the hand should be washed in the solution. The instruments and sponges to be used should be placed in this fluid, even as long as half an hour before the operation. Again, the 1 to 20 solution should be used in compound fractures and recent wounds, when the wound has been exposed to the air. Before the dressings are put on, the wound should be thoroughly washed out with this solution in order that any germs that may have found lodgment in it may be destroyed.

This 1-20 solution is too strong to use for any length of time, as it benumbs your hands so that it is very difficult to operate, and is, therefore, only used at the beginning of the operation to cleanse the surgeons hands and the parts to be operated on; the 1–40 solution then being substituted and continued, it being strong enough. The 1-40 solution) is used for the instruments and sponges during the operation.

I dwell on this point, as there is some difference of opinion as to the use of these two solutions. In order to settle this, I wrote to Mr. Lister and received the following reply.

12 PARK CRESCENT, PORTLAND PLACE, 11th Dec., 1877.

MY DEAR SIR:—In reply to your inquiry in your letter of Nov. 26th, received yesterday, I write to say that I use the 1 to 20 carbolic acid lotion for purifying the skin of a part about to be operated on, and also my own hands before I begin to operate, and for cleansing instruments and sponges, and also for the spray, when a steam spray producer is employed. The 1 to 40 lotion is our ordinary lotion used for the sponges during the course of an operation, (the sponges having been purified before the commencement of the operation with 1 to 20) and for washing the wound when requisite, and for the lotion in changing dressings. The 1 to 20, I should add, is used for washing (in order to purify them) wounds inflicted accidentally, such as compound fractures.

Thanking you for your kind report of the progress which antiseptic surgery is making in America.

I remain, yours very truly,

JOSEPH LISTER.

A good spray producer should break up the fluid into a fine cloud, the finer the better, as coarse spray soon wets the operator's clothing and condenses rapidly upon the bed, and the hands and clothes of the surgeon. The apparatus should be large enough to work for from one and a half to two hours at a time. This little one (Fig. 3) I have here will run for an hour and a quarter. They should be so arranged that they can be placed and maintained at any level that may be desired, and should also have a contrivance by which you can regulate the amount of heat by raising or lowering the flame.

All the spray producers which I here exhibit to you, have one

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fault—the flame not being protected by a piece of wire gauze, to make the light perfectly safe when using in proximity to ether; for in using these unprotected flames some serious accident will yet occur. Only a few days ago, while operating under spray, the flame of the lamp being a little below the level of the patient's head, the ether caught fire, and an explosion resulted which might have proved very serious. Fortunately, the patient was but slightly burned. Some of the lamps used are a little better protected than others, but they should all be surrounded with wire gauze after the manner of Sir Humphrey Davy's lamp, and thus made absolutely safe.

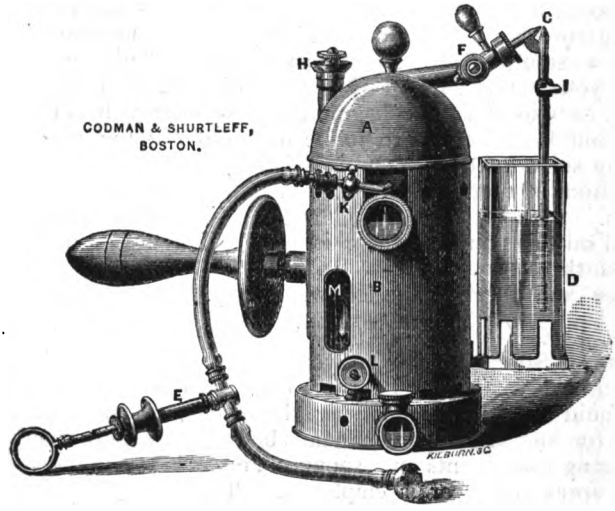

Fig. 1.

* The pump E is no longer used for the purpose of filling the boiler.

The best spray apparatus is, undoubtedly, that made by Codman & Shurtleff, of Boston, Fig. 1. By means of a window in the boiler, you areenabled to determine when the water is getting low, and by a similar arrangement in the lamp, the amount of alcohol present. It has an apparatus by which the flame is raised and lowered, so that you are able to regulate the force with which your spray is projected. The one which I here show you has a very fine tube, which produces a very minute breaking up of the fluid, giving us a light cloud of spray. It also has a stand, which makes it very convenient for hospital or clinic work, being so arranged that you can raise or lower it as you wish.

The next best instrument for this purpose is that of Dr. Weir, Fig. 2, which has the advantage of being cheaper than the one of which I have spoken. For hospital work it answers very well. It gives a good spray; this one, however, gives a much coarser spray than that of the Boston apparatus. This can be easily remedied.

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Its great disadvantage is that the spray-tube is fixed and the apparatus must be lowered or raised while operating, by the assistant. Moreover, the lamp-flame should be thoroughly protected with wire-gauze.

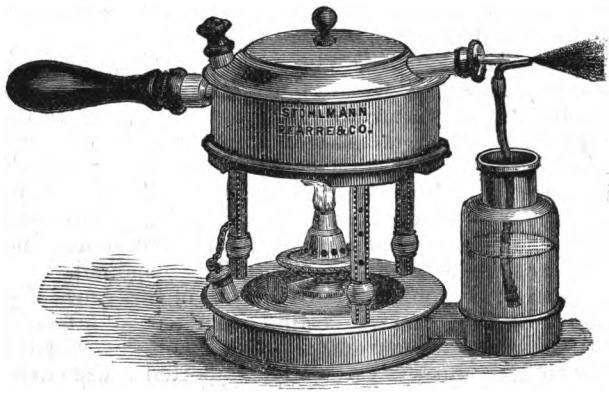

Fig. 2.

I have here a small instrument that has done me a great deal of service, Fig. 3. This is a Tiemann's Steam Inhaler, altered, at my suggestion, by Schmidt, so as to give a good spray. It answers very well for dressing wounds. For large operations, it is necessary to use the large spray apparatus, this small one answering well for

Fig. 3.

subsequent dressings. Mr. Lister uses a still smaller one for this purpose, which he carries in his pocket. This small one which I have, will work for over an hour. The best instrument is the one which makes the finest spray, it wetting and numbing the hands but

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little, and causing the fluid to last longer, while producing as good an effect upon the tissues. The spray-tube, in order to accomplish this, should be of small calibre. Dr. Weir states that if he wishes the solution to come up in smaller quantity he compresses the rubber tube. I think it is better, however, to have a finer tube, the same end being reached with much less trouble. Always be careful to see that the safety valve is right before you use it.

We will now turn our attention to the "antiseptic gauze." It is made of very course muslin, a sort of *cheese-cloth*, which is prepared in the following manner: Seven parts of common resin and five parts of paraffine are to be melted together over a water-bath, and one part of carbolic acid added. The latter should be slowly and carefully stirred in. Into this mixture the cloth should be dipped until thoroughly saturated, heated up to a certain degree of temperature, again thoroughly immersed in the mixture, folded and pressed sufficiently to squeeze out any excess of the compound.

There is one great objection to the use of this gauze if you get it in the stores—it is expensive, costing from ten to fifteen cents per yard. If you make it yourself in large quantities, it will cost but from four to five cents per yard. The imported gauze costs in single pieces from fourteen to fifteen cents per yard, while in quantity it can be had for from eleven to twelve cents. As considerable is used in each dressing, the cost is something to be considered.

It should be kept rolled up in a thick piece of brown paper. The resin and paraffine are used for the purpose of holding the acid firmly fixed in the meshes of the cloth and preventing its evaporation, which would certainly occur without them. This prepared gauze is used for covering wounds and making bandages for dressings.

Another material used is the Mackintosh cloth. It is an imported article and consists of cloth on one side and rubber on the other. It has a strong odor of carbolic acid, and is used to protect the parts from the atmosphere. Before using it, hold it up to the light and determine whether or not it contains any holes, for even a small pin-hole through it is liable to cause an unpleasant failure of the whole plan. A piece of rubber cloth, or rubber tissue, in fact anything of the kind will answer equally well. This, however, is supplied a little cheaper than the rubber tissue, and is, on that account, generally used.

There is another article used, know as Mr. Lister's "protective oil-silk." Both sides of it should be coated with a thin layer of copal varnish, and then covered over with a mixture consisting of one part dextrine, two parts starch, and sixteen parts of the 1—20 solution of carbolic acid. This is allowed to dry on the oil-silk. What is it for? It is called protective oil silk and is used to protect the wound from the action of the carbolic acid, for while this acid is all powerful in destroying germs, it will, if left in contact with the parts too long, prevent union or healing. Carbolic acid is only meant to come in direct contact with surface during the operation or while dressing it afterwards. A small piece of this silk laid over the wound protects it from the action of the gauze, which is laid above it. The rea-

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son that dextrine &c., are used is to enable it to become uniformly moistened when dipped in a watery solution.

In addition to the Mackintosh cloth and oil-silk, we must have some other appliances. Foremost amongst these in Mr. Lister's treatment, is rubber tubing. It is kept in open wounds for the purpose of drainage.

There are three sizes of this tubing, and it is used in this way: A piece of the tubing with a number of holes cut in its side is placed in the wound with one end just protruding from between the lips. To keep the tube from slipping either in our out it is a good plan to pass a thread and needle, previously carbolized, through the tube and skin, thus stitching it in for the first few days. This can be easily done while the patient is still under the influence of the anæsthetic, or a better way is to pass a thread through the end of the tube and fasten the thread to the patient's body, at some distance from the wound, by a piece of adhesive plaster. Unless you resort to some such expedient you will have trouble in keeping the tube in place.

These tubes, as I have already told you, are for the purpose of maintaining free drainage of the wound. If there is much discharge the parts should be daily cleansed with the 1-40 solution. If, however, the wound is doing nicely there is no need of this, it being simply necessary to cut off the tubing, piece by piece, as it is pushed from the wound by granulations until the last portion is reached, when you will remove it.

In introducing a drainage tube, it is always best to make a counter opening, if you can, so that you may have two openings through which to pass it. Mr. Lister has, lately, been using-cat gut ligatures and pieces of horse hair, instead of a drainage tube. These were first thoroughly saturated with carbolic acid and then drawn through the wound, a little bundle of horse-hair is easily retained, and, after a little time separates so that it can be easily removed one or two hairs at a time.

Another thing very necessary to the accomplishment of a perfect result, is to be able to do away with ligatures ; for if there is any foreign body in the wound, and a ligature is unquestionable such, it will excite inflammation generally, and produce irritation always. Therefore in all wounds where we try to get union by the first intention, we do away, as much as possible, with ligatures. Acupressure was the first step in this direction, torsion the second, and last and best of all, the cat-gut ligature.

They are thoroughly saturated with a mixture of carbolic acid, (one part dissolved in one tenth part it's weight of water) and five parts of olive oil. They should be left in soak for two or three months. It is best, I think, to buy them already prepared, and save yourself this trouble. They come in two or three different sizes, Their great advantage lies in the fact that after you tie them you can cut both ends off short and leave the knot in the wound, for the animal substance soon shrinks and dissolves, producing no irritation whatever. In cases where you do not care to apply antiseptic measures, the plain cat-gut ligature behaves in the same manner.

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In the operation for simultaneous ligation of the common carotid and sub-clavian arteries, which I performed about a year ago, I tied both vessels with this material. This procedure was very strongly objected to by some of the surgeons who were present. I tied them both very carefully and was particular to tie the square and not the surgeons knot, in order that the ligature might hold well. I then cut off both ends and left the knots in the wound. They caused no trouble whatever, and were never heard of again. I have never had a case of secondary hæmorrhage following the use of this material.

Sometimes it is necessary to use silk for sutures. They should be passed through a compound consisting of one part of carbolic acid to ten parts of melted wax, and dried with a towel, by which means any superflous material is removed. For sutures they are much better than cat-gut, as the latter soon melts and allows the wound to gap.

Mr. Lister also uses what he calls the "safety pins," which are so made that their ends will not penetrate the Mackintosh cloth, and allow germs to reach the wound. This shows how carefully he acts upon the idea that the air is deadly poison to the wound, and that it must, consequently, be thoroughly excluded from the parts. So strongly is he impressed with this idea that he says "a single pin-hole made in the Mackintosh cloth, might destroy the patient's life."

So much, then, Gentlemen, for the materials used in applying Mr. Lister's method to the treatment of open wounds.

At the next lecture I will describe in detail the manner in which these materials are used.

HOSPITAL RECORDS.

PRESBYTERIAN HOSPITAL, NEW YORK.

Reported by ALBERTO LACAYO, M.D.

GOUT, RENAL CIRRHOSIS, FACIAL ERYSIPELAS AND DEATH.—SERVICE OF DR. HADDEN.

John Timmons.—married.—aet. 46.—England.—Park-keeper.

Family History.—Father kept a tavern in England, and was in the habit of drinking quantities of malt and spirituous liquors. Had frequent and violent attacks of gout in big toe and foot. Died aet. 70. Mother still living and in good health.

Past History.—Came to the United States about twenty-one years ago. Worked in iron foundries for eight years, then obtained position as game-keeper at Central Park, which he has kept ever since. Has, for years, been in the habit of taking three or four drinks of whiskey or brandy a day. Four or five years ago, after exposure, he suffered from rheumatic attacks, lasting several days at a time. Had severe pain and swelling of the knee and elbow joints. Two years ago pain

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commenced in the joints of his fingers. There was swelling, soreness, and the deposition of chalky matter in the finger joints and helix of the ear. Some of the finger joints opened spontaneously, and discharged white, chalky matter. Pain came in paroxysms, and it and the swelling usually subsided in from four to six hours. The last attack of this kind occurred about five weeks before admission.

Present Condition.—Stout, well built, ruddy-faced Englishman. Complains of no pain, but great weakness, especially in the knees. Some discomfort in small of back. Eyesight has gradually failed him in the past year. Has no œdema, headache, epistaxis or marked diuresis, nor has he been troubled in this way in the past. There is a slight deposit of chalky material about the metatarso-phalangeal articulation of great toe of left foot. In the helix of each ear there are small gouty nodules. The tissues of almost all the joints of the hands are infiltrated with this material, especially the metacarpo-phalangeal joints of the little fingers. The skin over the joints is of a bright red color, and over the metacarpo-phalangeal joint of the little finger of the left hand, there is a small opening from which oozes some whitish matter, which, under the microscope, proves to be some pus mixed with a large amount of urate of soda. The urine, which is of low gravity, contains considerable granular and atrophied renal epithelium, and a few small hyaline casts. There is but a trace of albumen.

April 24th, '75.—Ord. propylamine gtts, ij. The urine, about 30 oz. in amount, contained a few small hyaline casts, and a trace of albumen. Urea, 15.76 grains to the oz. of urine.

April 27th, '75.—No improvement in the pain and swelling of the joints. Two very severe chills this P. M. Great pain in the left ear. Stopped propylamine.

April 28th, '75,—Ord. potass iodid, ℥ ij.
Vin. colch. sem. ℥ j.
Inf. gentian co, ℨ ij.
M.
Cap. ℥ j q. 3 hor.

Pain in small of back with frequent micturition. Ear much swollen and of a dusky hue; evidently erysipelas. Ord.

Acid carbolic ℥ i. } Use on ear.
Oleic acid ℨ i. }

Temp. 101.5° F. Ferri. chlorid M. xx. t. i. d.

April 29th, '75.—Ear about the same. Great pain in it during the night. No casts in the urine. Urea 5.36 grains to oz. of urine; amt. urine in twenty-four hours, 22 oz.

April 30th, '75.—Acid carbolic discontinued, and cold water dressings substituted.

Ord. quiniæ sulphat. gr. iv.
Pulv. ipecac. co. gr. x., at night.

May 1st, '75.—Erysipelas plainly marked and spreading rapidly, over face and scalp. Pulse weak. P't. very low. T. 103.6°.

May 4th, '75.—Delirious. Both eyes closed. Serum exuding from left cheek. An ulceration, somewhat blood stained, on right cheek.

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May 6th, '75.—Refused, in his wild delirium, to take any nourishment for past two days. Died, this P. M., from exhaustion.

At the autopsy twelve hours after death, the kidneys were found to be granular and contracted. The capsule was quite adherent in places, and tore off pieces of renal substance in being removed. The cortical portion was greatly diminished, and in its tubes and those of the pyramids, were found numerous deposits of the urate of soda. The sheaf-like crystals of this substance were also found in the spaces between the tubules. Throughout, the renal epithelium was granular, atrophied, and broken down, in some places completely filling the tubules as dark granular masses. There was an enormous amount of fibrous tissue everywhere. Small cysts existed here and there. Small hyaline casts, such as had been found in the urine, were present in some of the tubules. The walls of the arteries were somewhat hypertrophied, and the arteries themselves apparently dilated.

The heart was slightly hypertrophied.

[This case is one that is worthy of more than passing notice, as its history furnishes us with many points of interest. To those who believe that gout and rheumatism may and do exist in the same person at the same time, or that the one affection alternates with the other, this history furnishes an interesting study.

It is a question whether the first attack of joint trouble, which occurred five years before admission to hospital, was the primary manifestation of the gout, or a true attack of rheumatism. If the latter, it is certainly a rare occurrence, and one, if we accept the teachings of Garrod, which are undoubtedly sound, (viz. the entire absence of uric acid in the blood in rheumatism, and its presence in abundance in gout,) that needs some peculiarly severe exciting cause to explain the rapid appearance of the peculiar *materies morbi* of the gout, which followed closely upon the heels of the so-called rheumatism.

If, on the contrary, we accept the inflammation of the knee and elbow joints as the primary manifestation of the gout, we have a very unusual seat for its occurrence. He seems to have had but little trouble with the big toe, which is the usual point for the disease to first show itself. When appearing first in some other joint there is, almost without exception, some predisposing cause, as weakness of the part or parts from disease or from injury, recent or old. Although no such injury could here be determined, I think we may safely eliminate the rheumatism, and call the attack one of acute gout, affecting the knee and elbow. The man's family history, age and habits, all point to gout, and the conclusion is certainly justified by the characteristics of that disease, which showed themselves at a later date.

A second point of interest is the condition of the kidneys (cirrhosis far advanced). If not an exciting cause, the daily use of strong liquor was certainly a predisposing cause of the renal malady, and it seems that the gouty trouble had been under headway long enough to produce this alteration in the kidney structure. Indeed, there are those who believe that a gouty diathesis may manifest itself only in this form of renal degeneration; of this, however, there is no proof.

As is usual in these cases, there was no œdema, the heart's force

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and action being good. The urine seems to have been secreted in normal amount up to within a few days of death. This and the fact that the eyesight was in fair condition, seems to be due to the slight hypertrophy of the heart, and the fair condition of the arteries.

When he first came to the hospital, he was passing about a normal amount of urea (504.32 grains) in the twenty-four hours. Later, the amount fell to about 129 grains, although erysipelas was well under headway, and the heart's action not particularly weakened. The attending fever did not, as is usual, increase the amount of albumen.

Death from erysipelas in this form and degree of renal degeneration, without any uræmic symptoms, is not common, though it does occur.

In conclusion, it is a very rare occurrence to find crystals of the urate of soda deposited *between* the renal tubules. H. H. K.]

PERISCOPE.

COLLABORATORS.

Dermatology:
HENRY G. PIFFARD, M.D.
Diseases of the Nervous System:
EDWARD C. SEGUIN, M.D.
Diseases of Women and Children:
FRANK P. FOSTER, M.D.
General Surgery:
EDWARD J. BERMINGHAM, M.D.
Genito-Urinary Disease and Syphilis:
ROBERT W. TAYLOR, M.D.
Materia Medica and Therapeutics:
FREDERICK A. LYONS, M.D.
Ophthalmology and Otology:
SAMUEL B. ST. JOHN, M.D.
Orthopædic Surgery:
NEWTON M. SHAFFER, M.D.
Practical Medicine:
E. DARWIN HUDSON, JR., M.D.

INTRA-VENOUS INJECTION OF MILK AS A SUBSTITUTE FOR TRANSFUSION OF BLOOD.

Dr. T. Gaillard Thomas read a most interesting and valuable paper on this subject before the New York Academy of Medicine, on the evening of April 18th, 1878.—After referring briefly to the operation of transfusion of blood, and calling attention to the insecure position which it occupied practically, he passed to the consideration of substituting cow's milk for blood in the operation of transfusion. He called attention to the fact that although milk and blood were not homogeneous fluids, still there was not such a marked difference between chyle and milk, and the former was introduced directly into the blood as a normal physiological process. The operation was first performed by Dr. Hodder, of Toronto, about 1850, who employed it three times in the treatment of collapse in Asiatic cholera. Next Dr. J. W. Howe, of this city injected six ounces of goat's milk into the cephalic vein in a case of phthisis, but with no benefit to the patient. Dr. H. now made some experiments upon animals. He injected cows milk into the veins of five dogs, and they all died. Next came the experiments of Dr. Eugene Dupuy, which were made at the suggestion of Dr. Thomas, and which proved that milk could be injected without any baneful results. In these experiments it was

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found that cases of intra-venous injection of milk which had been removed from the cow for an hour or two (as had that used in Dr. Howe's cases) invariably proved fatal, while the injection of perfectly fresh milk was followed by marked benefit. The method employed by Dr. Thomas may be best illustrated by relating briefly one of his cases:—A healthy cow was driven into the yard of the hospital, and eight and a half ounces of milk drawn from her udder into a porcelain dish surrounded with warm water was permitted to flow slowly into the median basilic vein of the patient, from a glass funnel, to which was attached a rubber tube and a suitable nozzle to be introduced into the opening in the blood-vessel. A rigor followed the operation; the temperature rose to 104° F., but these symtpoms soon passed off, and the patient, who was moribund at the time of the operation, rallied, and left the hospital in about 3 weeks. Dr. T. has employed it in two cases since, making in all seven injections, and from his experience arrives at the following conclusions:

1. Injection of milk into the circulation in place of blood is a perfectly feasible, safe, and legitimate operation.

2. None but healthy milk, drawn from the udder of the cow within a few minutes of its introduction into the circulation, should be employed. It should be tested by litmus paper, and if found to be acid, should be made alkaline by the addition of carbonate of soda.

3. A glass funnel, with a rubber tube and a suitable pipe attached, was much better and safer than a more elaborate apparatus.

4. Intra-venous injection of milk was an infinitely easier operation to perform than transfusion of blood.

5. Intra-venous injection of milk, like that of blood, was commonly followed by a chill and rapid rise in temperature, but these symptoms soon subsided and were replaced by a great improvement in the general condition of the patient.

6. He would not limit lacteal injections to cases in which profuse and exhausting hemorrhage had occurred, but recommend their use in certain cases of typhoid fever, pneumonia, cholera, etc.

EARLY DIAGNOSIS OF STONE IN THE BLADDER.

Mr. Teevan read a paper on this subject before the Harveian Society of London, on April 4th, 1878. On the arrival of a stone in the bladder, it usually soon gave notice of its advent. The larger the stone was permitted to grow, the more trouble it gave in its removal. If treated when small, it could be dealt with satisfactorily. As to the amount of pain produced, a small oxalate of lime calculus would give rise to much pain, while a large smooth stone behind the prostate caused but little suffering. When the stone was small, there was often difficulty in micturition, from the stone plugging the urethral orifice. This was more apt to happen with boys than with men. The amount of pain produced by stone varied with the habits of life. Hunting often elicited early evidence of the presence of stone, and so had saved many a life. The blood passed with stone was by drops at the end of

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the act of micturition. Changes in the urine itself were of little value diagnostically. In children, incontinence of urine was often present with calculus; here the stone passed into the prostatic portion of the urethra, and the urine trickled past it's side. Such incontinence was of great diagnostic importance. The family history and the patient's history were often of much service. Rarely more than four of the above symptoms were found together in any one case. In stone-cases, there was little complaint at nights; while in prostatic cases the trouble at nights was usually great. Motion aggravated the symptoms and the pain in stone-cases, but did not affect stricture cases. A stiff bolster under the patient's buttocks was useful at the time of sounding. The finger in the rectum, and a short beaked sound, were of service. It was well to stand straight before the patient, and not on one side. By so doing, it was easier to bear in mind the three long prominences of the pelvis, viz.; the sacrum and the tuberosities of the ischia. The PRESIDENT, Dr. Graily Hewitt, referred to the late Mr. Liston's diagnosis of asking the patient to jump down from a chair. The patient emphatically refused.—*British Medical Journal.*

THE APPLICATION OF MAGNETS FOR THE REMOVAL OR DISPLACEMENT OF IRON AND STEEL CHIPS FROM WITHIN THE EYE.

Mr. Macdonald McHardy read notes of a case illustrative of such use of magnets before the Clinical Society of London, on March 22d 1878. The patient, a man aged 31, when at work, was struck in the eye by a fragment of steel from the hammer he was using. When seen, twenty-four hours after, there was evidence of commencing iritis; there was nothing in the vitreous; the eye was less painful than on the night of the accident; its tension normal. Atropine drops were prescribed. The next day there was no pain, and less congestion of the eye; the pupil was well dilated, and allowed of detection of a sharply defined opacity on the interior surface of the lens in a downward-inward direction from the centre, the peripheral end being nearer to the margin of the dilated pupil. The cornea was almost normal. The atropine was continued, and absolute rest enjoined. The removal of the chip appeared to be imperative, lest it should gravitate downwards; at the same time Mr. McHardy was unwilling to remove the lens, and he also thought if it were injured by the forceps it would not be easy to tell if any subsequent opacity of the lens were due to the original injury or to the operation. He, therefore, had a magnetic spatula constructed, intending to use it in connection with an electro-magnet. At the suggestion of Mr. Brudenell Carter the procedure was modified by employing a powerful bar magnet connected with two Grove's cells. Gradually approaching it to the front of the cornea, when it was four inches away, the chip sprang from the lens to the inner surface of the cornea, aud fell into the anterior chamber, whence it was removed, together with a small portion of iris. A patch of opacity exactly

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corresponding in size to the chip was left on the lens. Subsequently a cataract formed, and the injured lens became absorbed. The patient's vision, aided by a lens of twelve dioptrics, is normal for distant objects. Reference was made to a paper by Dr. McKeown, in the *Dublin Journal of Medical Science*, for September, 1876, where three or four similar cases are recorded. Mr. Carter stated that the position of the fragment was such that any other attempt at its removal would have jeopardized the eye. If nothing had been done, the fragment would probably have fallen below the iris, and would have set up destructive inflammation; and any attempt at its removal by forceps would certainly have injured the lens. By withdrawing it from its bed and bringing it to the front of the iris, the magnet had obviated these difficulties.—*British Medical Journal.*

NEWS ITEMS AND NOTES.

The Shrill Voice of American Women.—Is ascribed by the Rev. E. E. Hale, to the custom of requiring little girls to "read up," as it is called, in our large schools. The teachers expect a child of five to fill with her voice a room fifteen feet high and fifty feet square; as a consequence the child changes her low sweet home voice to the school scream; and in the course of time the school scream displaces the natural voice. The necessity of "speaking up" in recitation, so as to be heard across a large or noisy room, might be added as a cause of spoiled voices. That the school-room has this tendency may be noted any day in the extreme "clamor cry" of female teachers. We have known not a few sweet-voiced young ladies to acquire the discordant school marm voice very rapidly after taking charge of a large school-room; and possibly the little girls may acquire something of the tone by unconsciously imitating their teachers.—*Scientific American.*

Death from Fright.—The *British Med. Jour.* records the following very extraordinary case of death from fright. A female carrier by some means fell off her cart on the highway; and sustained rather severe injuries. She was conveyed to a house in the neighborhood, and the hostess received such a shock, from seeing the bleeding and bruised condition of the woman, that she died shortly afterwards from the effects of the fright.

Itemizing Accounts.—The *Louisville Med. News* publishes the following bill, which it says was actually rendered in Owen Co., Ky. and remarks.—"The baleful influences of specialism had probably not reached the neighborhood in which the services were rendered at the time the bill was made out, some years ago."

——— to ———Dr.:	
To seventeen visits, to ———	$8.50
To preaching funeral sermon	1.50
To shaving corpse	10
	$10.10

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Bottling Air for Future Examination.—During the Centennial summer samples of air were collected on various occasions upon the exhibition grounds at Philadelphia, and in the different buildings; also in this city, in Brooklyn, Hoboken, and on many of the Adirondack mountains, with a view to transmitting them to the chemists of 1976, to determine whether the earth's atmosphere is undergoing change. That the atmosphere has undergone enormous changes since the earlier geological ages is beyond a doubt. The present question is whether such changes are still slowly going on, and what their nature may be. The ordinary statement that the air has an invariable composition is not strictly true, since samples of air collected at different times and in different places are never found to be absolutely identical. The difference may be slight, but an apparently insignificant decrease in the percentage of oxygen becomes of grave importance when the deficiency, as is usually the case, is made up of less beneficial elements.—*Scientific American.*

Russian Soldier's Bread.—An analysis of the bread issued to Russian troops in Bulgaria, showed that it contained nineteen per cent. of saw dust and fourteen per cent. of sand.

New Disease among Wool Sorters.—Dr. Bell, of England, has directed attention to a new disease among wool sorters, which has been developed since the introduction of mohair and alpaca into the trade. Sudden and unaccountable deaths took place among the workmen, which at length became so frequent as to create alarm. Eminent medical and scientific men have been consulted, and post mortem examinations made, but the cause and nature of the disease were not satisfactorily explained. The symptoms of a typical case might be summarized as follows: No rigor, thirst, pain, vomiting, nor purging; no expectoration, quick breathing, great exhaustion, weak rapid pulse, clear mind, extremities cold, perspiration clammy, gradually decreasing temperature, death in fifteen to twenty-four hours. Dr. Bell attributes the disease to the inhalation of a septic poison produced by the decomposition of animal matter in damaged bales, producing septicæmia.

A New Sense.—M. E. Cyon has sent a note to the French Academy, in which he claims that the eighth pair of cerebral nerves contains two nerves of entirely distinct senses—the auditory nerve, and the nerve of space (*Raumnerv*). He regards the latter as the source of all our ideas of extension, and of three dimensions of space.—*Med. and Surg. Rep.*

Trial of Endurance.—Of "trials of endurance" now so much in vogue the latest is that undertaken by Mr. Murphy, of Kern, California, who talked incessantly for twenty-four hours, with a rest of five seconds in each hour, for the purpose of taking a drink of whiskey. At the conclusion of his task, Murphy fell from his chair, but whether this was the result of exhaustion or of intoxication, could not be determined.

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Notice.—Subscribers and advertisers are notified not to pay to Walter Ireland any moneys for subscriptions or advertisements due this journal, as he has no longer any authority to act for us. Remittances should be made directly to this office, or accounts may be settled with any duly authorized agent.

A Phenomenal Dose of Morphine.—Dr. J. H. Thompson, of Goshen, N. Y., has sent us the following, which is not without interest. "Yesterday I witnessed the taking, by a woman in a drug store, of thirty-seven grains of sulphate of morphine. She is a gypsy-appearing, sallow complexioned female; fleshy; seemingly about fifty years of age, and apparently in the enjoyment of good health. Though not a permanent resident, she is well known here by the druggists, who are well acquainted with her practice of purchasing, and taking on the occasion of purchase, incredible quantities of tincture of opium or morphine. She states that the amount above indicated is her usual dose every other day, when available. The drug produces no visible effects upon her.

The Obstetrical Gazette.—This is the title of a new monthly journal to be devoted to obstetrics, and the diseases of women and children. It will be published in Cincinnati and will be edited by E. B. Stevens, M.D., for eighteen years editor of the *Cincinnati Lancet and Observer*. The first number will be issued in July, and the subscription has been placed at $3 per year.

Pregnancy at Eight Years.—The *Gazette Hebdomadaire* reports a case of extraordinary precocity in a girl eight years of age. She was born fully developed, and had hair on the pubes, menstruated at four years of age, and was seduced and became pregnant at eight. The pregnacy resulted in a mole containing a well characterized embryo. The father was a hopeful of 13 years.

The Women's Hospital.—Drs. J. E. Janvrin and H. Goldthwaite have been appointed assistant surgeons to the Women's Hospital, on the staff of Dr. Bozeman. No better selection could have been made.

Diagnosis of Pregnancy.—Dr. Goodell calls attention to the following sign of pregnancy:—"When the neck of the uterus appears to you as hard as the end of your nose, pregnancy should not exist; if it appear to you as soft as your lips, the uterus probably contains a fœtus.

Proportion of Physicians to the Population:

Country.	*Population.*	*No. of Physicians.*	*Proportion.*
United States,	44,874,814	62,383	1 in 600
France,	36,100,000	19,902	1 in 1,814
Great Britian,	32,412,010	19,385	1 in 1,672
Germany,	41,060,695	13,686	1 in 3,000
Austria,	35,904,435	14,361	1 in 2,500
Canada,	3,575,577	2,998	1 in 1,193

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THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY.

A WEEKLY JOURNAL OF MEDICINE, SURGERY AND THE COLLATERAL SCIENCES.

EDITED BY

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EDITORIAL.

THE UNUSUAL IN MEDICINE.

It has been said that every nation at some period of its existence has a besetting sin that gives to its people certain peculiarities that are distinctive. We say sin, because it always comes about, that, though in the end, working to a certain extent to the good of mankind in general, it always proved decidedly harmful to the people amongst whom it existed. Whether this be so or not, for we have no time to discuss the matter fully now, we, of the present day certainly have our failings; and one more prominent, perhaps, than the rest.

It is the fact that we are very curious, very credulous, and very easily humbugged. As, for the production of bacteria or the hatching of the eggs of the "blow fly," it is necessary that the conditions favoring their production should be present, so, for the production of human frauds, two-legged blow flies, it is necessary that the minds of a people where they are to exist, should contain the elements favorable to their production. The mind of the average American is, certainly, in just such a condition, and, as a consequence, we have and have had our Barnum and his "*What Is It*," our Cardiff Giant, our minds

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readers, our cancer plant, our Homeopathists, our blue glass cures and our thousand-and-one thimble-riggers, whom we have confidingly allowed to humbug us, paying handsomely for the privilege.

This much to show how the mind of man, especially that of the American, is essentially curious. There seems to be a constant longing to find something odd, something strange, something "out of the usual run." We are a people intensely interested in the marvelous, a people in search of physical and metaphysical five-leaf clovers.

Medical men, though there are many of us loth to believe it, are only human. The mind, possibly possessing some hereditary taint, that is constantly surrounded and acted upon by other minds filled with this longing to meet with or discover something strange, must of necessity become more or less affected with the same desire, and a two or three years course in a medical college is by no means sufficient to alter it's tendencies and make it purely scientific. Is it any wonder, then, that there are Barnums in our profession, or that we carry with us in our every-day practice, in our scientific work, in our thoughts, this very element of curiosity that was our constant companion until we undertook our profession?

Were this peculiarity confined to the gentlemen high up in our ranks, and, like a lady's pet poodle, kept for individual amusement, it would work us less harm. The fact is, however, that the most infatuated are those in the middle and lower ranks. A cursory glance at the contents of the medical journals of the present day, or a few moments listening to the conversation of two medical men reveals to us very plainly that, some of us at least, are sacrificing the essential for the purpose of enjoying the unusual.

Students and physicians will put themselves to considerable trouble in order to see some unusual operation, that it is probable most of them will never see performed again, and almost certainly never perform themselves, while they neglect to see and study closely many operations that are really of more importance to them, though less interesting. We are becoming sadly callous to the necessity of attending closely and carefully to details. They are so small, so common place so uninteresting, we plead. How by thus drudging through life, attending to little things, can we discover great things; how thus become Brights or Jenners? Take care of the pennies and the dollars will take care of themselves," so look out for details and great things will come of it.

Let this very unscientific craving for the unusual, the marvelous, that exists in its highest form amongst the ignorant, be checked and the neglect of lesser things, which attention to it entails, be more carefully looked after, our profession is already filled with brilliant dreamers, somnambulists who walk through life with the eyes of their common sense closed fast, men who stand one third on mental terra firma and two thirds in the clouds. We need no more of these. We want less of the theoretical, less of the unusual in our journals and our conversation, aye, in our work; and more, much more that is practical. When this becomes the rule we shall accomplish more and better scientific work, and give the people physicians who know their business.

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It is true that a knowledge of the unusual is not without its good points. It serves to fix in our minds the usual. This we do not deny, nor that its usefulness lies in this alone. It would, however, be folly to attempt to learn all we need know by first finding out what is unusual. The moral that we try to teach is this—Do not neglect the small things of importance and known usefulness, for a knowledge of the unusual, however interesting it may be.

LECTURES.

TWO LECTURES ON LISTER'S ANTISEPTIC METHOD OF TREATING SURGICAL INJURIES.

Delivered at the College of Physicians and Surgeons, New York.

BY

JAMES L. LITTLE, M.D.

Lecturer on Operative Surgery and Surgical Dressings in the College of Physicians and Surgeons; New York. Professor of Surgery in the Medical Department of the University of Vermont. Etc.,

[Reported for THE HOSPITAL GAZETTE.]

LECTURE II.

GENTLEMEN:—In order to successfully practice Mr. Lister's Antiseptic Method, it is necessary that we should believe, or act as if we believed, the atmosphere to be loaded with germs that are poisonous to open wounds, and, moreover, that the vitality of such germs may be destroyed by a proper use of antiseptics. By keeping these facts in mind, and endeavoring to follow Lister's directions to the letter, we will accomplish results hitherto unparalleled in the annals of surgery.

I am, as you can see, a firm believer in Mr. Lister's method of treatment, and was so persuaded by seeing results from it that I had never seen before. For the last twelve years Mr. Lister has been working out his plans to perfection. The first attempt he made was to use carbolic acid in the dressing of an abscess. Having applied it to the surface on a piece of lint, he raised the edge of the latter, opened the sac and let the pus drain out thoroughly.

After this he began to use the spray, then dressings on tin-foil, and finally reached the point that seems to be as near perfection as possible, i. e., his present method. Mr. Lister was recently called to fill the chair of Surgery in London in place of Sir William Fergusson, who lately died. At the time when he came to London there were but few Surgeons who either believed or practised his method, and as a consequence, his first operation in this way, was attended by many men eminent in the profession, who were anxious to witness, and ready to condemn it. A patient with simple fracture of the patella was brought into the amphitheatre, and etherized. Prof. Lister laid open the joint, cleaned it out, wired the bony fragments together, made an opening for the drainage tube, inserted it, and closed the

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wound. All procedures were of course carried out after his method. The patient fully recovered, the temperature not having at any time gone above 99°.

As you well know, an opening into the knee-joint, was, up to a very late date, an exceedingly dangerous matter. Even a small penknife puncture in this situation has often brought about a fatal result, and we had come to consider such openings as serious as wounds of the abdomen. Nevertheless, in this case, Prof. Lister not only cut down and exposed the parts, but having wired the fragments, left a drainage tube in the joint and the patient recovered with no rise in temperature and an excellent joint. Gentlemen, such results are simply unparalleled.

I wish, for a few moments to call your attention to all the materials used in performing an operation according to Prof. Lister's method. We must have.

1*st.* A steam spray producer.
2*nd.* A solution of carbolic acid, 1—20
3*rd* A solution of carbolic acid, 1—40
4*th.* Antiseptic gauze.
5*th.* A piece of Mackintosh cloth or rubber tissue.
6*th.* Draining tubes. If you fail to have these, soft catheters will do. If you have neither, a few shreds of horse hair will answer the purpose.
7*th.* Bandages made of antiseptic gauze.
8*th* Cat-gut ligatures.
9*th.* Carbolized waxed ligatures.

These are the paraphernalia necessary to perform an operation after the Lister method. In addition all surgical instruments commonly used in other operations, are here employed. Looking over the list of additions to an ordinary operation you may think that they must of a surety interfere with the rapid and proper performance of the operation. This, however, is not the case after you are once thoroughly familiar with their uses, the operation becoming as simple and easy as when performed without them.

The following is the method carried out by Mr. Lister in performing any important operation. First, have on hand all the articles that I have named, being especially sure that your spray apparatus is in good working order. It is better to have two, in case one gives out. You next send your assistant to the house, have the table prepared, and the sponges and instruments placed in the 1—20 carbolic acid solution. The patient being anæsthetised your assistants and yourself prepare for the operation. Your hands should be first washed with soap and water, taking care to cleanse the nails thoroughly with a brush. They should then be dipped in the 1—20 solution, and the patient's wound or the parts upon which you are about to operate, sponged off with the same, after being also washed with soap and water.

Afterwards your 1—40 solution comes into play, one or two basins of it should be on hand. Into this your sponges and instruments are to be dipped during the operation. For the sponges and instruments

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soup-plates or the old fashioned delf pie-plates will be found very convenient.

When the operator is ready the spray should be started. The apparatus should be in the hands of a careful assistant whose duty it is to keep the cloud of spray constantly falling on the wound, never for a moment directing it elsewhere. As the surgeon changes his position, so should the assistant, so that he may not be interfered with. If the operation is to last long some support will be needed for the spray producer, if not, it is best for the assistant to hold it himself.

During the operation, the instruments that have been used should be carefullv wiped and replaced in the carbolic solution. Some of you may think that all these precautions are quite unnecessary, but let me tell you, Gentlemen, that it is only by carrying out fully and carefully these details, that the best results are obtained. These spray producers are very unpleasant to use, for they throw the spray in all directions; it gets in your face and mouth, and benumbs your hands. Still this does not justify us in dispensing with the spray altogether, as some surgeons have done. Moreover, the surgeons who have neglected to use it, have failed to get such results as I have described to you; results that are quite easy of attainment, if Mr. Lister's most excellent rules are followed out in detail.

During the operation a cat-gut ligature may be needed, one or two should be taken from the bottle where they are kept and placed in the Carbolic Solution (1—20) and left there until wanted. They should be about a foot in length. When needed, one should be handed the gentleman who is to tie the artery. He ties it, snips off both ends of the ligature and lets the knot remain in the wound.

Another thing—during the operation the solution in which your sponges have been cleansed will soon become very turbid. It is not necessary to throw this out and add fresh fluid, for a thorough squeezing out of the sponges is all that is necessary, before you use them again. "It is *surgically pure*" says Mr. Lister, "as long as it contains a sufficient quantity of carbolic acid."

The operation being completed, the drainage tube should be inserted if necessary and the parts brought together with either cat-gut or carbolized silk sutures. The former should never be used where there is, or is liable to be much tension, for they are apt to melt away in a short time. If there has been much oozing during the operation, a carbolized sponge should be placed in the wound as a compress, and left there until the next day. The rest of the dressings I will describe in a few moments.

Let me call your attention now, gentlemen, to the manner in which a wound should be treated when it has been exposed for a longer or shorter period to the atmosphere, and the germs it contains. Suppose you have a compound fracture. Air has certainly found access to the tissues, and with implicit faith in the germ theory, we at once proceed to disinfect the parts, or, in other words, to put them in an antiseptic condition.

The usual treatment of such a condition is a strong argument in

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favor of Mr. Lister's method. You have been taught that if a person suffers from a simple fracture anywhere, be it single or multiple, if there is no external opening, nothing need be feared, so far as suppuration is concerned. Though the swelling be great, it will soon go down, the serum be absorbed, and union of the fragments and healing of lacerated tissues take place without the formation of pus. But if, with the fracture, you also have an external wound, (viz. a compound fracture) the prognosis is very different, unless you succeed by immediately closing the wound, in converting it into a simple fracture, free suppuration will take place, and the pus may burrow about in every direction, erysipelas or pyaemia may result, and death end the story. All this simply because air was admitted to the lacerated tissues.

The prognosis between a simple and compound fracture, is, as I have already said, very different; the former very good, the latter very grave indeed. If, therefore, we can by any treatment whatsoever give to the compound fracture the same prognosis as to the simple, we are undoubtedly doing a great work. This is the very thing Mr. Lister aims to accomplish, and succeeds in doing with his method of treatment.

To do this the wound should be first thoroughly washed out with the 1–20 solution of carbolic acid. A common Davidson's syringe will answer all practical purposes, and if unable with any of its nozzles to reach every part, a flexible catheter, previously thoroughly steeped in carbolic acid solution may be passed in, and the wound be carefully and fully injected, so that all parts are washed with the solution. In this manner the wound has been put in an antiseptic condition. All this, if possible, should be done under the spray, so that while the dressings are being applied, no germs may enter.

It is in just this way, gentlemen, that the most surprising results have been produced. For the past ten years, probably, certainly for the past eight, we have been applying this principle in our hospitals, to the treatment of such injuries, only it has been done less thoroughly. The wound was washed out with a carbolic acid solution, not always fully, however, and then protected from the atmosphere with some simple dressing, such as lint soaked in carbolized oil. Lacerated wounds are brought into an antiseptic condition by washing them thoroughly with the 1–20 solution.

Now, gentlemen, I will describe the manner of applying the dressings after an operation, antiseptically performed, or after a compound fracture or lacerated wound has been brought into an anticeptic condition, by washing out with the 1–20 solution. You should always do your dressings under the spray. This is very important. After the wound has been brought together, and the hæmorrhage checked, and, if necessary, a drainage tube inserted; you must take a single piece of protective oil silk, previously immersed in the 1–40 solution, and simply lay it over the wound. It should be large enough to cover the wound; over this should be laid one or two thicknesses of the prepared gauze, thoroughly saturated with the 1–40 solution. This is to destroy any germs that may have lodged upon the surface of the subsequent dressings. The part is now covered with from six

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to eight layers of the gauze, previously prepared with a piece of the Mackintosh cloth an inch less in diameter all round, placed underneath the upper layer. The smooth surface of the Mackintosh cloth should be turned toward the wound, These should be retained in position by a roller bandage made of the same antiseptic gauze. The eight layers of gauze, together with the Mackintosh cloth, should be large enough to extend a good distance beyond the wound in all directions. For instance, as I show you on this mannikin, if the wound to be dressed is just below the elbow, the dressing should be long enough to extend some distance above the elbow joint; and down, covering in the hand; and sufficiently wide to envelop the limb The last dressing can be secured with the "safety pins," taking care that they do not pierce the Mackintosh cloth.

The reason we use so much dressing is for full protection, and so that we need not dress the wound often ; not oftener than once in three, four or five days ; the rule being to keep the dressing on until the discharge finds its way to the outside. As soon as this occurs, the dressing should be changed. In our hospitals, the moment this takes place, even if at night, the house surgeon is called up to redress it. Sometimes the number of dressings are so few that the surgeons task is comparatively light,

During the first twenty-four hours there is usually a very extensive discharge of serum from the surface of the wound ; so great, indeed, that it may even in this time saturate all the dressings. This being the case, it is of course necessary to again dress it. As I have already said, if the wound is large, it is best to put on a very thick dressing. *You should not disturb a dressing unless there is pain, an oozing through at some point, or a rise in temperature.*

The fact that there are cavities in the wound, in some cases, which will fill with serum, shows how necessary a drainage tube is. The use of the drainage tube may, however, be carried to excess. In several amputations of the breast I did not consider this necessary. I simply brought the cut surfaces accurately together by means of compresses and applied Lister's dressings. They healed very nicely. Where this can be done there is no need of a drainage tube. If this cannot be done, by all means, use a drainage tube, cutting a hole in the oil-silk through which it may pass.

This matter of the drainage tube is of such importance, that Mr. Lister claims great results from its use ; the wound being thoroughly drained by it. Where there are accumulations of pus and serum there is an elevation of temperature, and the surrounding parts soon become inflamed.

Sometimes you can leave on the dressings a week, ten days, or even two weeks at a time, and often when you think it necessary to renew the applications, you are agreeably surprised to find the wound healed. I have already told you how you can know when the wound needs redressing.

In making your after-dressings you should have everything ready ; gauze, another piece of Mackintosh cloth, bandages, and the carbolic solution (1-40). The spray apparatus should be in perfect order, and

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so held as to throw the spray into every little pouch and crevice of the wound; in fact, so that it shall reach *every* part of it. The dressing should be gradually removed until you come to the last layer. If everything looks well and there is no discharge, simply put on fresh layers of gauze and a piece of Mackintosh cloth. If, however, there is pain and an elevation of temperature, it is necessary to remove all the dressings under spray, examine the parts closely, and put on fresh dressing throughout.

You will find a tendency for the drainage tube to slip into the wound. How to prevent this I told you in my last lecture. The drainage tube should be allowed to remain in until the second or third dressing, if there is any discharge. If not, take it out. If so, it is well to wash the wound thoroughly with carbolic solution and re-introduce the tube. Mr. Lister has said, however, that unless there is some evidence of putrefaction going on in the cavity there is no need of washing it out. How can we determine that such changes are taking place? The piece of oil-silk lying next the wound is the "tell-tale," the danger signal, for if decomposition has taken place, and sulphuretted hydrogen or any bad gases are there generated, this oil-silk becomes discolored, and tells us plainly that the antiseptic method has failed. This being the case, you must at once inject the wound with the strong carbolic solution thus trying to get it back to its original condition, and renew the dressing.

If, during an operation or dressing, the spray gives out, it is best to have a piece of gauze on hand which you dip in the carbolic solution, and immediately throw over the wound, until your apparatus is in working order again, or another has been procured. Thus you protect the parts from the atmosphere.

A word now about wounds that have existed for some length of time. Suppose we have an old ulcer of the leg to deal with. Mr. Lister does not consider the carbolic acid dressing alone sufficient in these cases. He uses a solution of the chloride of zinc 1 to 12, which he paints over the ulcer with a brush. The pain is very intense, but does not last long. After the wound is thoroughly couterized in this way, Mr. Lister applies his usual dressing for wounds, under-spray.

In operating for necrosis or caries, after exposing the sinuses, you should thoroughly cauterize them by injecting the zinc solution into them. You may then proceed to dress the wound in the usual antiseptic manner. I cannot urge upon you too strongly the necessity for carrying out fully all these little details. I might state in conclusion, gentlemen, that Prof. Volkmann of Halle, has used in his clinic for some months past, thymol solution, in place of carbolic acid. This solution is made of the strength of one part thymol to 1000 parts of water. The formula as given by Dr. W. T. Bull of this city, is as follows:

			Grammes.
Thymol,	grs. xvss		1.0
Alcohol,	ʒ iij	or	10.00
Glycerine,	ʒ ss	or	20.00
Aq.,	℥ xxxiv	or	1000.0

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It is claimed that this solution does not irritate the surface of the wound, and consequently the "protective oil-silk" may be dispensed with. The gauze is made in the same way as with carbolic acid, except that spermaceti is used in place of paraffine. The proportions are 1000 parts of gauze, 500 spermaceti, 50 of resin and 16 of thymol.

The disagreeable odor of carbolic acid is entirely avoided by this dressing. This substance is now being tried in the New York Hospital. I have have not yet had an opportunity of using it.

CLINICAL REMARKS ON A CASE OF THORACIC ANEURISM (?)

Delivered at Bellevue Hospital, New York.

BY

ALFRED L. LOOMIS, M. D.

Professor of Pathology and Practice of Medicine in the Medical Department of the University of New York.

[Reported for THE HOSPITAL GAZETTE.]

This patient states that she has a tumor in the chest. She complains of trouble in swallowing, and says that she first noticed it about a year and a half ago. She can feel something obstructing the food and preventing its easy passage to the stomach. She also says that her voice has changed, it formerly being louder and not so hoarse. She has had a cough since the commencement of the difficulty, and likewise had a pain in the chest from the first, which has continued ever since. The symptoms have decreased since she went into a hospital, which is about eleven months ago, but up to that time they had steadily become worse. The difficulty in swallowing, she thinks, is somewhat better.

Previous to her present illness she often had neuralgia in the head. She also had rheumatism in the joints. Never had sore throat, but once had a rash over the body, which occurred about sixteen years ago. At the same time she lost her hair. She did not have rheumatism at that time; this occurred about six or seven years later. It was worse at night, but the trouble was not located in the shafts of the bones, the pain being limited to the joints. She has never had any children, and was married eighteen years ago. The rash and the falling of the hair occurred about three or four years after marriage.

On examining the chest of this woman, you notice a little prominence, but it is not very well marked. The question would immediately come up between aneurism and a mediastinal tumor. Difficulty in swallowing is one of the rarest primary symptoms of aneurism. It usually comes later on, after the tumor is well developed.

I remember one case, however, in which it was the only symptom, and death occurred from a rupture of the sac into the œsophagus. In that case the aneurismal tumor was developed in a peculiar position.

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The ascending part of the arch of the aorta had enlarged backward against the œsophagus.

On percussion, we find dullness over an area extending from about the middle of the clavicle on the right to the same distance on the other side.

I find the upper part of the sternum evidently thickened and I cannot get my finger behind that bone. There seems to be some mass developed behind the bone, and the more I press my finger to go downward, the more it is carried backward as though there were something closely attached to the back of the sternum, and carrying the finger back toward the trachea.

On auscultation, a murmur is heard at the junction of the cartilage of the second rib with the sternum on the right side, which is not heard at the base of the heart. This murmur which is not harsh in character, but rather soft, might be produced by pressure. There is an indistinct pulsation. There is no difference in the radial arteries.

We here have some symptoms of aneurism, with a history of gradual pressure on the œsophagus and trachea. The symptoms seem, however, to be less than they were before, as she states that there has been some improvement during the last year. All this, however, is possible and there still may be an aneurism. These considerations though, would lead us away from aneurism. I do not positively assert that there is no aneurism, I am only guarding my diagnosis.

That which leads me to doubt the existence of an aneurism is the fact that, as I pass my finger behind the sternum I find it thickened, and something attached to it which presses my finger upward and backward and does not allow it to pass down behind the bone. From this, and also from the fact that she is apparently improving, and that all the symptoms, the murmur and pulsation included, may be produced by pressure exerted by a mediastinal tumor, I am led to hold my diagnosis in abeyance till further developments make the case more clear.

ORIGINAL ARTICLES.

SPASMODIC CROUP—PULMONARY ŒDEMA—DEATH.

BY

H. H. KANE, M. D.

Amy A, aet. 17, mos. N. Y., female.

Family History—Grandparents living. Father a large, well built, healthy blonde. Mother of a decidedly nervous temperament; otherwise perfectly healthy. Neither lung trouble, brain or venereal disease on either side, so far as known.

Past Hisiory—Child weak and anæmic from birth, although tenderly and judiciously cared for. Had a similar attack about a year

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ago, which was pronounced by a regular physician to be spasmodic croup and which yielded readily to treatment.

On the evening of the 11th of October, the mother drove to Babylon, a distance of ten miles, taking both children with her. They did not get back until 9 P. M. The night was "raw" and cold, and the little one, though well wrapped up, coughed considerably on the way back. Once home she was thoroughly warmed and put to bed. Though feverish and restless almost all night, she awoke on the morning of the 12th inst. and seemed almost as well as usual.

About 11 A. M. she managed to get hold of a bottle of alcohol from which she took a swallow. She at once made outcry and was hurriedly given some syr. ipecac, and soon vomited, seeming quite relieved. At 1 P. M. she nursed well, and also eat a little potato. About 2 P. M. she began to complain of her throat and chest, constantly putting up her hands and crying. She soon began to cough and about 4 P. M. a distinct crowing sound was heard with each inspiration. The cough and stridulous breathing were exactly like those of the attack of one year ago.

The child was put to bed and free diaphoresis established and kept up. Fearing a membrane in the throat the mother took a neighbor's advice and gave the child a quantity of lard and salt rubbed up together, to make it vomit. Warm water, some homeopathic pellets, and syr. scillæ were also given, by the advice of friends. The child getting no better, more of the lard and salt mixture was given, also some ipecac. The finger, handles of a spoon and a tooth brush were then thrust down the throat successively, partly to break up the membrane and partly to cause vomiting.

About 9 P. M. the dyspnœa increased and a rattling sound was heard in the lungs. The crowing sound was marked on both inspiration and expiration. The child was perspiring freely, but the mother considering that more vomiting would be of benefit, and the little one not responding to the other remedies, fresh warm urine was poured down its throat. She sank rapidly now and died about 11;45 P. M.

Dr. Hammil of Islip and myself were called about 11;30 P. M. but did not reach the house until after the child's death. We found it a small delicate child, very pale, lips bluish, and a pink, frothy fluid oozing from between the lips.

Autopsy—16 hr's. after death. Rigor mortis well marked.

Thorax—On opening the chest the lungs did not collapse, were everywhere of a pale bloodless appearance save at the lower and posterior parts of both, where there was some hypostatic congestion. On pressure or section a considerable quantity of frothy serum oozed from both lungs. No clots in pulmonary vessels.

Some reddening of bronchial mucous membrane. At points there were slight ecchymoses, Tubes contained much frothy fluid. Trachea normal. Larynx normal. No false membrane, and not the slightest redness or swelling of its mucous lining. Tonsils and back of pharynx normal.

Heart—Right auricle and ventricle contained considerable dark blood. No clots. Left auricle and ventricle contracted and empty.

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Abdomen—All organs normal except the stomach, the mucous membrane of which about the pyloric end and partway up the greater curvature was of a deep bluish red color and considerably softened.

HOSPITAL RECORDS.

CHARITY HOSPITAL, JERSEY CITY.

Reported by DANIEL MCMARTIN, M.D.

CEREBRAL EMBOLI.—LEFT HÆMIPLEGIA.—DEATH.

Joseph Ragge.—aet. 47.—Italy.—Single.—Silk-weaver.

Was quite well up to three months ago, at which time he commenced to have frontal and occipital headache. Ptosis of the left eye then came on slowly. On the 27th of December, while at work at his loom, he fell from his chair to the floor. Did not loose consciousness. On trying to rise he found that the entire left side of his body was paralyzed. The ptosis disappeared and there was neither lingual paralysis, aphasia, nor any interference with deglution. Sensation on the left side entirely lost. Had full control of bowels and bladder.

On admission (Dec. 30th), sensation and motion on the left side were found impaired. Says that he has improved greatly since the attack. Is unable to walk without entire support for the left side. Right pupil contracted, left normal. Was ordered strychnia sulphat. with pyrophosphate of iron and dilute phosphoric acid.

Jan. 3d.—Motility of the left side somewhat improved. Temperature of the left leg somewhat below that of the right. Had a little headache in the evening and complained that the left leg felt very cold. It was somewhat benefitted by friction.

Jan. 8th.—Walks without support, though with tottering steps. Temperature of both legs the same. Appetite good. No headache for several days.

Jan. 25th (9 A. M.)—Continued to improve until to-day, when, at the above time, he suddenly fell from his chair. On rising, he found the power in left arm and leg considerably diminished. Complained that the sensation of coldness had returned to the leg.

Jan. 27th.—At 1 A. M. he was taken with spasmodic contractions of left extremities, which lasted about an hour. Made frequent efforts to micturate, which were at first futile, but were soon relieved by a free gush of urine. Strychnia, iron, etc., stopped.

Jan. 28th.—Muscular twitchings have not returned. Passed urine through which the blood was diffused and in clots. Not understanding English well he could not comprehend or answer intelligibly questions regarding his sensations. Ordered quiniae sulph. in moderate doses, and the application of an ice-bag to the perinæum and hypogastrium.

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During the night he tried to rise several times, and when restrained, laughed. At 5:30 the paralysis of the left side was not complete as he helped to raise himself. At 7:30 the muscles of this side were in a state of tonic contraction.

Jan. 29th.—Patient comatose. Both pupils contracted to the size of pin-head. Ordered sinapism to extremities and a stimulating enema.

9 *A. M.*—Condition about the same. Face and hands somewhat cyanotic. Body warm and moist, having been perspiring freely. Passed urine twice during the night. Pulse 100. T. normal. At 10:10 patient suddenly stopped breathing for about one minute and the pulse at the wrist almost disappeared. Both pupils were well and uniformly dilated. Gasped two or three times at long intervals and was thought to be dead.

At 10:15 began to gasp more frequently and then breathed regularly. Pulse came up to 100, and was distinct, though weak. Right pupil contracted; left dilated and irregular.

6 *P. M.*—Patient in same condition.

Jan. 30.—(9 A. M.) Condition unchanged since yesterday. Some slight evidence of consciousness when face is tickled. Occasional changes take place in the pupil. Pulse 78 and of moderate firmness. Resp. 18; more regular and with less stertor. Temp. 99°. After 12 M. he commenced to sink, and died at 4:30 P. M.

Autopsy, 40 hours after death. Rigor mortis fairly well marked. Body extremely well nourished. Incision in median line showed considerable adipose tissue in parietes of trunk.

Lungs deeply congested and œdematous. *Heart*, *spleen*, *kidneys* and *liver*, normal.

Brain—Weight, 52 oz. Deep congestion over surface of right hemisphere with discoloration from transfused blood. The cerebral and basilar arteries contained little nodular bodies, that on section proved to be emboli. They were always found at a point of bifurcation and extended into both branches. They were quite firm, non-adherent to the tube, and of a white, yellowish-white and pinkish color. Connected with each choroid plexus posteriorly was a whitish body, about the size of a garden bean, one of them when cut into, let out a watery fluid.

GOOD SAMARITAN HOSPITAL, NEW YORK.

REPORT OF SURGEON FOR THREE AND A-HALF MONTHS ENDING MAY 1ST 1878.

NEW YORK, May 2d, 1878.

To the Board of Managers of the Good Samaritan Hospital:

GENTLEMEN:—I beg to submit to you the following condensed report of the service in the Out-Patient Department, since the opening on the 16th of January, 1878. During the brief time that has elapsed, and notwithstanding the fact that your institution is but little known, either to the medical profession or to the laity, the fact has been satis-

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factorily demonstrated that it is destined to occupy a prominent place among the many noble charities of which our city is justly proud. During the three months and a-half that the Out-patient Department has been opened it has afforded treatment to no less than 69 patients, classified as follows :

Nationality.—Ireland, 25 ; United States, 24 ; Germany, 9 ; England, 5 ; Canada, 2 ; France, 1 ; Sweden, 1 ; Italy, 1 ; Cuba, 1. Total, 69.

Age.—Below 10 years, 2; from 10 to 20, 5; 20 to 30, 19; 30 to 40, 19; 40 to 50, 14; 50 to 60, 6; 60 to 70, 3; over 70, 1. Total, 69.

Sex.—Males, 53; females, 16. Total, 69,

Duration of Disease.—Less than 1 year, 24; 1 year, 9; 2 years, 11 ; 3 years, 6 ; 5 years, 6; 7 years, 2 ; 8 years, 1 ; 10 years, 9 ; 14 years, 1. Total, 69.

Results of Treatment.—Cured or relieved, 60; sent to hospital, 4 ; left service, 4 ; discharged incurable, 1. Total, 69.

Classification of Diseases.—Abscess, 1; condylomata (syphilitic), 2 ; habitual constipation, 3 ; coccygitis, 1 ; fissure 1 ; external fistula, 1; complete fistula, 10; recto-vaginal fistula, 1; fatty tumor of buttock, 1; fish-bone imbedded in rectal wall, 1; impacted feces, 1; incontinence of feces, 1; external hæmorrhoids, 12; internal hæmorrhoids, 8; mucous patches, 3; neuralgia, 1; lacerated perineum, 1; pediculi, 1; enlarged prostate, 2; prolapsus, 2; pruritus, 4; polypus, 2; stricture, 1; ulceration, 4. No diagnosis made, the patients not having returned after receiving instructions as to cleanliness, 4. Total, 69.

Operations.—The following operations have been performed, either at the Out-Patient Department, or at the patients' houses :—Ligation of internal hæmorrhoids, 4; fistula in ano, 7; removal of external hæmorrhoidal tabs, 5; removal of fatty tumor of buttock, 1; removal of fish-bone from rectal wall, 1; removal of impacted feces, 1; removal of polypus, 2; opening abscess, 1; incising fissure, 1. Total, 23.

Owing to your wise adoption of the "Provident System," the medical attendants have been enabled to refuse treatment to several patients whom they considered were not entitled to gratuitous advice. The number of patients applying for treatment with a family income of between 10 and 15 dollars per week has been very small, so that the amount realized from this source during 3 1-2 months has only been one dollar. This amount has been received from three patients, all of whom seemed to contribute their mite for the benefit of the institution, willingly.

EDWARD J. BERMINGHAM, M.D., Surgeon.

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PERISCOPE.

COLLABORATORS.

Dermatology:
HENRY G. PIFFARD, M.D.
Diseases of the Nervous System:
EDWARD C. SEGUIN, M.D.
Diseases of Women and Children:
FRANK P. FOSTER, M.D.
General Surgery:
EDWARD J. BERMINGHAM, M.D.
Genito-Urinary Disease and Syphilis:
ROBERT W. TAYLOR, M.D.
Materia Medica and Therapeutics:
FREDERICK A. LYONS, M.D.
Ophthalmology and Otology:
SAMUEL B. ST. JOHN, M.D.
Orthopedic Surgery:
NEWTON M. SHAFFER, M.D.
Practical Medicine:
E. DARWIN HUDSON, JR., M.D.

HYPODERMIC INJECTIONS OF CAMPHOR IN INSOMNIA.

N. E. Wittich, assistant physician to the Lunatic Asylum of Heppenheim, near Tübingen, reports (*Berlin, Klin, Wochenschrift* No. 11, 1878) success in the treatment of the insomnia of female lunatics, by camphor. He gives from 1½ to 3 grains in wafers by the mouth. He has also employed hypodermically a solution of 1 part camphor in 10 parts of oil of sweet almonds with even better results. W. does not state how much of this solution he injects, but the quantity is probably the same as that used internally. He asserts that no irritation or inflammation follows this procedure, even after repeated injections. He recommends that the needle used be rather large. E. C. S.

A PROPERTY OF SULPHATE OF QUININE NOT WELL KNOWN.

This property consists in the modification it causes on suppurating surfaces when it is applied locally. The injection of a solution of 60 centigrammes of sulphate of quinine in 60 to 100 grammes of distilled water is very advantageous in the treatment of empyema. This same injection is efficacious in gonorrhœa, and an ointment of sulphate of quinine exercises a cicatrising action on wounds and chronic ulcers. The injections of quinine have the same action on suppurating cavities and fistulous tracts.—*Gazetta Medica Italiana.* F. A. L.

RABUTEAU ON THE ACTION OF FERROCYANIDE OF SODIUM ON THE ELIMINATION OF UREA.

M. Rabuteau in a communication to the *Société de Biologie* reports the results of his researches on the action of the ferrocyanide of sodium, which has been recommended as a diuretic. He concludes from his experiments that the salt is not diuretic, that it is eliminated without change, and moreover, the elimination is slow, it taking more than 80 hours for the elimination of 30 grammes of the salt.—*Gazette des Hôpitaux.* F. A. L.

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CORRESPONDENCE.

SCIATIC DISLOCATION.

Eds. Hosp. Gaz. & Arch. Clin. Surg.:

I find that what I described in your journal of January 1st, 1878, as a "hitherto unrecognised symptom" of sciatic dislocation, had been recognised and well illustrated by Oscar H. Allis, M.D., one of the surgeons to the Presbyterian Hospital, in the *Philadelphia Medical Times*, of March 28th, 1874. I hasten to accord to that gentleman priority in presenting the subject to the profession.

Although I had had three cases illustrating the symptom, the first in the summer of 1871, and had demonstrated it to my classes every winter since, and had often spoken of it to my professional friends, yet Dr. Allis' paper had entirely escaped my attention.

In 1871 I was called to see a case of hip dislocation by Dr. J. W. Hadlock, in which I first recognised the symptom in connection with sciatic luxation. With my first manipulation I threw the head into the thyroid hole, by another, I dislodged it, but it slipped into the notch, but in taking this position it did so with such a thud that Dr. H. and myself imagined that the head was in the acetabulum. I extended the leg and found it of corresponding length with the other, but as soon as I removed the force, the deformity again occurred. This confused me as it had others before and since. I flexed the thighs upon the pelvis, and *the knee of the affected side sunk below the other one inch and a half*. The nature of the accident was then plain to me. After reducing the bone I went to my office and demonstrated the symptom with the skeleton to Dr. Hadlock.

In October, 1874, Captain Williamson came to me with a sciatic dislocation of nine weeks' standing. I demonstrated the symptom to my class and felt the head in the notch through the rectum as suggested by Squires. In attempting reduction I fractured the neck.

Again, in 1877, I treated a case of sciatic dislocation in a little boy. The symptom was well shown and recognised by my associates, Drs. N. Foster G. B. Orr, and Charles Anderson.

This is another illustration that one should not hurry into print with new discoveries, but as I had waited almost seven years after my first demonstration, and as "no author, so far as I had read, had called attention to the difference in the length of the dislocated limb when extended, and when flexed at a right angle with the pelvis," I thought that I had found "a hitherto unrecognised symptom."

That Dr. Allis' paper had been overlooked by others, will be seen by the fact that since my paper was published I have received letters from a number of distinguished surgeons, who, recognising the sign as new, assured me that it would hereafter be known as my test. It must, however, be called "*Allis' Test*," for it is apparent that he first, through the press, called the attention of the profession to this most valuable factor in determining the nature of obscure as well as of simple cases. Although my first patient was treated in 1871 and Dr. Allis' in 1872.

Respecfully,

W. W. DAWSON.

Cincinnati, O., April 30, 1878.

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ABOUT BOOKS.

Modern Surgical Therapeutics; by George H. Napheys, A.M., M.D., etc. Revised to the most recent date. Philadelphia: D. G. Brinton, 1878., *pp.* 587.

This work, although chiefly a compilation, is in some respects something more than this. It claims to represent the teachings and practices of the most eminent surgeons of the day, as regards "the *therapeutics* of surgery in the stricter sense of the word, to gather their formulæ, * * * *, to systematize their therapeutical directions, and to set forth their specific treatment of surgical diseases and injuries."

Such a work, from its very nature, is one eminently suited to commend itself to the practitioner as a valuable work of reference. To have before him in a single volume, properly arranged and classified, the multitude of various and often opposing methods of treatment adopted by the most distinguished leaders of the profession, and which they have found from long and observing experience to be the most useful, is an advantage that cannot be easily estimated. The work occupies a field which hitherto has been empty.

There is no attempt made to reconcile different methods of treatment where these are opposed to one another, but they are given under the name of the authority by whom they are recommended, and the surgeon is left to select for himself, in accordance with his own views and experience. At the same time numerous resumés are made and these in most instances show clear and correct judgment, and moreover a vast amount of labor in collecting the materials from which conclusions are drawn.

A valuable feature of the work is the immense number of formulæ that are presented. A common objection to such formulæ, and one that very often carries with it considerable weight, is that their use is apt to lead to a routine practice in the treatment of disease, the surgeon confining himself to a number of stereotyped prescriptions and losing sight of varying conditions that often call for deviations from his usual rule, according to the exigencies of individual cases. This is too true, and when a man confines himself to such a set of formulæ he ceases to be a scientific practitioner and degenerates into a medical hack. In most cases, understanding the peculiar conditions of each individual case, and the principles of action of the remedies he wishes to use, it is preferable for the surgeon to make his formulæ extemporaneously, and thus follow a more scientific process. This is the great danger of all such collections of set prescriptions, and as there is always a greater or less tendency to fall into a fixed groove and follow a certain routine, we should all the more carefully endeavor to guard against it, and place obstacles in the way of such proclivities.

But on the other hand if we look at certain formulæ of this kind in the right light, extracting the principle involved from the mere form, they become useful aids in many cases. We know that certain remedies act very differently in combination with others than when they

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are used alone, or in certain other combinations. To be able to obtain such effects, merely using the formulæ as examples, is one of the chief arts in therapeutics.

Then again some surgeons claim to obtain certain results from some specific agent or agents and others fail in the same cases, in many instances the failure being due to want of knowledge of the proper method of use or of combination. In such cases set formulæ are often useful.

Looking at them, then, from the proper point of view, and not slavishly following a certain prescription because it is recommended in a certain disease by a certain authority, such collections of formulæ as the present work contains are valuable. For the reasons above mentioned, "*Naphey's Surgical Therapeutics*" might be regarded in different lights by different individuals, some viewing the work with favor and others condemning the principles on which it is based, as unscientific in method, but on the whole, taking a proper two-sided survey, it must be considered as a work of great usefulness, and will undoubtedly become a favorite with the profession generally.

Its scope is large and it covers the entire field of surgical diseases. A brief condensation of the table of contents will serve to show how much ground it covers. I. Therapeutics of inflammation. II. Anæsthetics (general and local). III. The dressing of wounds. (In this part is given a clear and concise detailed description of Lister's antiseptic method). IV. The complications of wounds (erysipelas, gangrene, etc.) V. Special forms of wounds. VI. Lesions from heat and cold. VII. Lesions of the connective and muscular tissue. VIII. Lesions of the bones and joints. IX. Lesions of the organs of circulation. X. Lesions of the organs of digestion. XI. Lesions of the organs of urination. XII. Lesions of the organs of reproduction. XIII. Lesions of the organs of special sense; (the nose, the eye, the ear). XIV. New growths, (benign and malignant). XV. The treatment of scrofula. XVI. Diseases of the skin. XVII. Venereal diseases.

The authorities, whose methods of treatment are detailed, belong neither to one section nor one school, and are well known all over the world as exponents in their departments. On glancing over the index of authors we find no less than 650, very many of course, being referred to in more than one section.

The book is furnished with full and copious indices of authors remedies and diseases, and is printed on good paper, in excellent type.

NEWS ITEMS AND NOTES.

Suit for Malpractice in a Case of Fracture of the Femur.—Non-Suit.—The following appeared in a daily paper entitled, *Advance and Press*, published at New Bloomfield, Perry Co., Pa., April, 1878:—"Jas. B. Weaver, by his father and next friend, Jonathan Weaver *vs.* Dr. M. B. Strickler. About the 10th of March, 1877, James B. Weaver, who is a boy of 8 years of age, sustained a fracture of the thigh bone

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of his right leg while engaged in wrestling with his brother. Dr. M. B. Strickler was called in and adjusted the fracture, and treated his patient for a fracture of the thigh bone. The treatment it was alleged was not correct, and it was held that there was no fracture at the place treated for. A large number of the physicians of the county appeared on the stand as witnesses for the plaintiff, but their testimony failed to make out a case against defendant. Their testimony was to the effect that the leg was five-eighths of an inch short, and that it was an ordinary good job.

On the part of the defendant, Dr. Agnew, Professor of Surgery of the University of Pennsylvania, and Dr. Hunt, Surgeon of the Pennsylvania Hospital and Professor of Orthopœdic Surgery, of Philadelphia, were called to the stand. They testified that they had made a thorough examination of the limb, that they found evidence of an oblique fracture extending from the knee joint to the upper third of the femur ; they stated that on a strict measurement they found the fractured limb only five-eighths of an inch shorter than the other ; that on requesting the boy to walk around the room in his stocking feet they did not discover any perceptible limp in the boy's gait. They also stated that they had measured the limbs of different persons and found a difference in length, where no fracture or injury had ever been sustained, and a boy of this place who never had a fracture or injury of limbs; and they found a difference of three-eighths of an inch. They said that the treatment was skillful and correct, and there was no deformity of the limb in this case beyond that usually resulting from such complicated fractures of this most difficult bone to treat when broken. On the conclusion of Dr. Agnew's testimony, the counsel for the defendant took a non-suit. W. A. Sponsler and Jeremiah Lyons, for plaintiff; W. N. Siebert, C. J. T. McIntire and J. E. Junkin, for defendant."

From a correspondence with Prof. Hunt, one of the witnesses for the defence, which has been shown to us, we learn that the facts as above reported are correct. There was some difference of opinion as to the exact point of the fracture. The limb was treated with only lateral, or coaptation splints. All agreed that it was about five-eighths of an inch shorter than the other. The boy alluded to in the report, whose limbs had not been broken, but in whom one limb was found to be 3-8 of an inch shorter than the other, was the brother of the lad whose thigh had been broken, and twelve years old. Profs. Agnew and Hunt, together with other surgeons, concurred in the result of this measurement, and when these facts, with others, were presented in court a non-suit became inevitable.

This is probably the first time in which the observation recently made by a number of careful observers* of the frequent absence of symmetry in the opposite limbs of the same person, has been offered in court as a defense against a prosecution for malpractice. It is, no doubt, destined hereafter to occupy a conspicuous place in this class of cases.

*Chiefly through the efforts of Dr. Jarvis S. Wight, in a paper published in this journal, Feb'y, 1877, which has been extensiveiy copied both in this country and abroad.

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With the views which we entertain, however, of the proper treatment of such fractures, somewhat better results may, *in most cases*, be expected from other and more efficient methods. We speak now particularly of fractures of the thigh in children. Whether this limb was originally 5-8 of an inch shorter than the other, and whether, therefore, in this particular case a better result would have been possible, we are unable to say, and in our opinion the court was right in giving to the defendant the benefit of the doubt.

Contagion by Mail.—The London *Telegraph* has recently published a correspondent's letter, setting forth a remarkable instance of scarlet fever being communicated by a letter. A lady wrote to a friend to inform her that she was nursing her daughter, suffering from scarlatina. The friend, after reading and burning the letter, gave the envelope in which it was contained to one of her children to play with. Shortly after, the child became sick of the same disease, which the physician traced to his own satisfaction to the affected letter. It might be suggested that an examination into the prevalence of contagious maladies among Post Office employés would throw some light on the danger of a possibly infected mail. One letter capable of communicating scarlet fever or small pox would probably render every other missive in the same pouch equally dangerous as a disseminator of disease. At any rate it is on the safe side to send no communications from infected houses save those that are absolutely necessary, and these should be immediately burned.—*Scientific American.*

Sickness in the Russian Army.—That disease is often more fatal to an army than actual warfare is again strikingly illustrated by the latest accounts from the East. It appears that the Russians are dying at Erzeroum in large numbers. Drs. Ryan and Stokes assert that 21,000 Russians have succumbed to typhus fever during the last three months in the city and plain of Erzeroum. There is also much sickness amongst the Russians at San Stefano, owing to defective camp arrangements and the dirty habits of the troops.—*Med. Press & Cir.*

A Remarkable Case of Morphine Tolerance by an Infant.—Dr. J. L. Little reports (*Am. Jour. Obstet.*, April, 1878) a case where paregoric in small doses was administered to a child three weeks old, for the relief of suffering caused by an inflammation of the knee-joint. The child gradually bore larger and larger doses—the paregoric was changed to tr. opii., and this again to Magendie's solution. Soon the child obtained such a tolerance of this drug that, in a couple of months, from half a drachm to a drachm a day was necessary to quiet it. This state of things continued until *the amount consumed by the child, then less than eight months old, was two ounces of Magendie's solution in twenty-four hours.* The dose was gradually diminished at the rate of about three drops per day, and at the time of making the report, but ten drops were given at bed-time. The child's appearance improved very much; it is intelligent, and weighs eighteen pounds.

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THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY.

A WEEKLY JOURNAL OF MEDICINE, SURGERY AND THE COLLATERAL SCIENCES.

EDITED BY

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LECTURES.

A CLINICAL LECTURE ON SOME RARE FORMS OF SKIN DISEASE.

Delivered at the University Hospital, Philadelphia.

BY

LOUIS A. DUHRING, M.D.,

Professor of Clinical Dermatology in the University of Pennsylvania Medical School.

[REPORTED FOR THE HOSPITAL GAZETTE.]

ELEPHANTIASIS ARABUM.

The patient is thirty years of age and unmarried. Her health was perfectly good until she was ten years old, when the glands in her axilla began to swell. They were poulticed and then lanced, but there was no discharge. This attack of adenitis confined her to her bed for a month. Shortly after her recovery her right arm below the elbow began to enlarge, and, in a day or so, became greatly swollen and very painful, the skin growing red and tense. These acute symptoms lasted only about a week, but recurred regularly once in every

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few months ; each recurrence driving the symptoms further down the arm. At fifteen years of age she began to menstruate, and the attacks were postponed for a year ; then she was again subject to them at regular intervals. At first the local swelling subsided entirely between the attacks, but gradually the enlargement became permanent, and the limb increased in size with each succeeding year. In every instance, the attacks were ushered in by a chill, followed by fever.

The attack from which she is at present suffering, began about seven days ago. She tells me that she woke up in the morning with a headache and feelings of general *malaise*. Her arm at once grew swollen, stiff and painful, the skin assuming a dense red appearance. In the course of thirty-six hours bullae came on the wrist and between the fingers. The cuticle of the arm and hand desquamated rapidly, and the afflicted member grew more and more painful, red and hot.

The extended history which we have of this case, throws a great deal of light on the processes of this disease, although those processes are not so well defined, and their results not so well marked as is sometimes the case. To-day, the woman is convalescing. Her arm is still very painful as she holds it up thus, before you. The inflammatory induration, as you see, has not extended above the elbow, at least, but very slightly above it, for just at the elbow joint there is still a great deal of swelling. The arm illustrates the peculiar pinkish hue of the skin in the disease. This coloring is generally diffused over the whole surface. Towards the wrist the tissues have become very much hardened. Even now, that the acuteness of the attack is over, the hand is swollen out of all natural proportions. The fingers can be moved but slightly. The skin is hard, very thick, very glossy, and a deep pink in color. In fact the whole limb, below the elbow, is very much in the same condition as we should expect to find in severe erysipelas. Of course the woman can do no work while these attacks last.

I have not time to-day to give you in detail the history of the disease known as elephantiasis arabum—its causes, symptoms, pathology, diagnosis and treatment. Suffice it to say that in this country it is very rare. In India, Japan, and in fact throughout the far East, it is very common. You must be careful to draw the distinction between elephantiasis arabum and elephantiasis of the Grecian writers; i. e., elephantiasis graecorum. The latter disease is that generally called leprosy—the most baneful disease known to the Grecian writers. It was distinguished by fungous growths about the face and joints, and atrophies and droppings off of parts, leaving the unfortunate sufferers frightfully scarred and disfigured.

Elephantiasis arabum is an hypertrophy of the connective tissue—elephantiasis graecorum is a new formation, so you see they possess nothing in common. Elephantiasis arabum ordinarily affects the lower extremities. There have been two well-marked cases of it in the Pennsylvania Hospital quite recently. In one of these cases Dr. Thomas G. Morton performed the operation of nerve-section upon the afflicted limb, and so succeeded in effecting a permanent cure. I

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have one other case in my wards at the Philadelphia Hospital at present. With these exceptions there have been but few examples of the disease in this city of late years. In the year when the University Hospital was first opened, there was a very marked case of scrotal elephantiasis arabum at Prof. John Neill's clinic. Dr. Neill removed from that man's scrotum a mass weighing between thirty-five and forty pounds.

It is easy to confound this disease with recurring erysipelas or with inflammatory disease of the skin, following the touch of poison ivy, etc. In the latter case there is generally found, upon questioning, to be a distinct history of poisoning, and once over, there will, of course, be no repetition of the symptoms. Here the disease has recurred regularly for twenty years. Between the attacks of recurrent erysipelas, the inflammation generally subsides entirely; in this disease the enlargement is permanent. Even in countries where this disease is common, it is rare to find it attacking the arm, much more is it the case in this country. I never remember to have seen a case like this before. The prognosis would be grave, here, even where it possible for something to be done to prevent the recurrence of the attacks. Various treatments with this purpose in view have been proposed. I have never placed much confidence in any of them. A celebrated Calcutta physician has spoken very highly of repeated doses of the iodide of potassium—the drug to be continued for weeks, or even for months. This woman has been upon no treatment whatsoever. I was afraid at first that she had been applying arnica (which only intensifies the pain and swelling) surreptitiously, but upon close inquiry, I found that such had not been the case. In one instance, which came under my notice, a hand poisoned by repeated applications of arnica, looked identically like this one.

ERYTHEMA NODOSUM.

This little boy presents the symptoms of a disease which I do not think any of you have seen here before. Like elephantiasis arabum, it is a disease very rare in Philadelphia. As far as I can gather, it is also very rare in New York and Boston.

I have made the little patient stand on the seat of this chair, and you can all see plainly these two (one on each leg) contusion-like lesions, on his shins. Looking at them leaves the impression that the child has fallen down and bruised his shins.

Some authorities consider this disease as entirely distinct from erythema multiformum, while others regard it as but a separate manifestation of the same disease. I am inclined to side with the latter form of belief, and to regard it as one of the same family to which erythema papulatum and tuberculosum belong.

These two isolated nodes on the lad's shins, when I examine them closely, are found to be hot, with central whitish spots. To-day, I see that the whitish spots have been replaced by greenish disks. These did not exist yesterday. It is a well known fact that all the erythematous diseases are associated with a play of colors. It runs from red to deeper red, to blue, purple, green, orange, yellow.

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The boy first noticed the local spots of soreness three or four days ago. The disease rarely lasts over two or three weeks. The mother tells me that the child was slightly sick four or five days before the nodes made their appearance. Young subjects are very likely to have constitutional disturbances. The nodes come out suddenly, at night perhaps, on one or both legs or arms, occasionally on the forehead. They look so much like bruises that the mother seeing the child in the morning supposes he has bruised himself in falling out of bed. There is no limit to the number of nodes which may appear. I have seen as many as twenty lesions cropping out over legs, thighs and forearm. Whether the number be small or large the whole limb is generally swollen and is so hot and painful that the child can scarcely walk during the first few days of the attack. These acute symptoms do not last long, but the discoloration of the parts lingers in some cases through two or three weeks. This little fellow has improved vastly within the past day or so. When I last saw him it was only with the greatest difficulty that he could limp along.

The disease ordinarily appears in the spring-time. Occasionally I have known of its occurrence in the fall. With regard to the pathology of the affection we know but little. It is generally supposed to be an inflammation of hemorrhagic nature. A great many opinons have been expressed as to its cause. Dermatitis contusiformis, a name which I proposed several years ago, expresses very satisfactorilly I think, the nature and local appearances of the disorder.

Treatment of course can be only palliative.

CLINICAL REMARKS ON A CASE OF RHEUMATIC AFFECTION OF THE SHOULDER IN AN INFANT.

Delivered at the College of Physicians and Surgeons, New York.

BY

ABRAHAM JACOBI, M.D.

Clinical Professor of Diseases of Children.

[Reported for THE HOSPITAL GAZETTE.]

GENTLEMEN:—The baby that I now show you, is six months old, and up to last Sunday morning, which is three days ago, was quite well; at that time, when dressing the child, the mother noticed that it could not move its arm, and when she attempted to lift it, or caught hold of its hand, it cried from pain. It was unable to move the arm until yesterday, when again it had slight motion. The child has slept well since the commencement of the trouble, and did not cry when it was left alone, the pain only arising when any attempt was made to move it.

It appears then, from the history, that three days ago the child could not move its arm, and that any attempt to move it caused such pain as to make it cry. Now, what conditions would give rise to such symptoms? Something certainly occurred, and you might readily think of a number of accidents that might happen around the shoulder joint. It might perhaps at first be suggested to you that the

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clavicle had been broken, and you proceed to a more thorough examination. The history however informs us that the loss of power of motion lasted only a short time, as the child soon recovered some of its ability. In fracture of the clavicle, on the other hand, the loss of power would have lasted at least eight or ten days.

Again, it might have fallen out of bed and hurt the shoulder joint, but there is no swelling nor ecchymosis, the remains of which certainly should still be seen, if such an accident had occurred The right arm does indeed look a little larger than the left, but this often occurs in infants as well as in adults. It might be that the arm had been pulled strongly and the muscles strained, but the mother says that she is very careful, and as there are no signs of violence, and have been none, this is not very probable.

On questioning still further we find that the mother sleeps near a window which is sometimes left open, and the baby lies with the affected arm towards that side. It may be then that during the night it became uncovered and was exposed to a draught of cold air. There is nothing to be seen, and as the history points to a rheumatic origin, the greatest probability is that the exposure to cold was the cause of the difficulty. There is no change in the lower extremities.

You may have thought, gentlemen, that this is a somewhat trifling case, but it is interesting in the way of diagnosis. When I first looked at the child in the ante-room, in a cursory manner, while selecting the cases for the clinic, without examining carefully, my first impression was, that it was a case of essential paralysis of the upper extremity, but on hearing the history and looking over the child more thoroughly I changed my opinion. In such a case as this the diagnosis might be wrongly made, and I have no doubt that it often is erroneous, and I wished particularly by this example to impress upon you the necessity, in every case, of thoroughly examining and going into the history of your patient before rendering an opinion, no matter how trivial it may at first sight seem.

There is no change in this limb, no fracture or dislocation, although we have tried hard to find one.

Still another point that first induced me to believe that there was paralysis, was that the sound side offered more resistance to being moved, but there is not very much muscular power in a child like this, and the affected arm may feel more comfortable in not resisting force than in endeavoring to restrain motion. You would think that in rheumatic trouble it would be less painful to keep the limb quiet and to prevent all motion, and this is usually the case, but not always, as the muscular contractions in resisting the force, might give more pain than a passive state, allowing the arm to be moved.

As regards treatment there is scarcely anything to be said. The case will do very well if left entirely alone. It is probably neuralgic in character, and does not require active measures.

We ought not, however, to dismiss the case, without knowing that it might not turn out so well, as we have said, and that the prognosis might not be so favorable. A chronic arthritis or a progressive atrophy of the muscles in the neighborhood, such as sometimes oc-

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curs in joint diseases might come on, and many cases of this description may be traced primarily to the occurrence of a strain or cold. All such colds, as they are called, are an affection of the peripheral nerves, and a true neuritis may result. The inflammation of the nerve may ascend or it may spread in both directions, to the periphery and the center, and a large number of cases of myelitis are due to peripheral trouble in the beginning. There may be no fever or general symptoms at first, but the disease may extend until all the symptoms of myelitis are developed. A peripheral origin is more common than a central one in most cases of myelitis.

HOSPITAL RECORDS.

ST. VINCENT'S HOSPITAL, NEW YORK.

REPORTED BY J. J. ULLOA Y GIRALT, M. D., HOUSE SURGEON.

ENCEPHALOID CANCER OF THE LEFT FEMUR.

K. M.,—aet. 28.—Ireland.—Admitted Oct. 24. '77.

Family History.—Very good.

Past History.—She never complained of any sickness previous to her present illness, with the exception of an attack of rheumatism, which occurred about three years ago, and from which she completely recovered. On the 21st of last June, she jumped out of a country wagon, and thinks she injured herself, as since then she has been unable to walk well, and has suffered from pain in the left limb, which extended from the knee to the middle of the thigh. About four weeks ago the pain extended to the hip, and has since been very severe, being worse at night.

On Admission.—A tumor, about the size of an orange, was observed at the middle of the left thigh. Patient said she never noticed any swelling previous to her jumping from the wagon, and she believes that this is the only cause of the tumor. Physical examination revealed no lesion of any of the viscera.

By *Nov.* 12th, the tumor had increased considerably, having extended from the middle of the thigh to the groin. The following are the measurements of the two thighs.

Right Thigh.—Circumference (about the middle) 19 inches.

Left Thigh.—Circumference (over tumor) 25 inches. About this time she began to complain of considerable pain and tenderness in the tumor.

Nov. 13th.—An exploratory puncture was made with an aspirator needle and nothing but a little blood was drawn off. Dr. Charles Phelps, the attending surgeon, called in consultation the medical and surgical staff of the hospital, and after a careful examination it was decided that it was a case of cancer of the femur, amputation at the hip-joint was advised, but as the patient refused to allow it, n. could be done but wait for the end.

Nov. 26.—Measurement over tumor 27½ inches.

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Dec. 10th.—Measurement 29½ inches at this time there was considerable œdema of the limb below the tumor.

Jan. 23rd.—Tumor measured 32½ inches; œdema of both limbs.

Feb. 12th.—Tumor measured 35 inches.

Mar. 19th.—Circumference of diseased thigh 39 inches. Considerable œdema of the upper as well as the lower extremities. Patient greatly emaciated, and the cancerous cachexia well marked. The treatment since admission has been purely anodyne. Hypodermic injections of Magendie's sol. of morphia (m. xv.) were made in her arms morning and evening. The dose was gradually increased and lately she has had hypodermically,

at 8 A. M.	3 i.	Magendie's Solution.
1 P. M.	3 ss.	" "
5 P. M.	3 ss.	" "
9 P. M.	3 iss.	" "

or 3 iij.ss. in the 24 hours.

Mar. 30th.—An ulceration was noticed about the middle of the tumor. It discharged profusely and soon became gangrenous, the discharge becoming very offensive.

April 2nd.—Patient died.

Autopsy.—(April 3rd) I first made an incision in the long axis of the limb, and then two transverse ones at the upper and lower end of the thigh. I tried to dissect up the skin but found it impossible, as the cancerous mass was very soft, and adhered firmly to the integument. Considerable cancerous juice, the odor of which was very offensive, was constantly running. The cancerous mass extended from the lower fourth of thigh to Poupart's ligament.

Neither the muscles nor fascia were to be found, the cancer taking the place of everything. Mixed with it were clots of blood in different degrees of organization and a great number of bony concretions. Blood-vessels were abundant. Although I looked carefully for the femoral artery and vein, I could not find them. All that remained of the femur was the head, a small part of the anatomical neck and the lower fourth of the bone. The rest was completely destroyed.

ST. FRANCIS HOSPITAL, NEW YORK.

REPORTED by W. H. HAYNES, M.D., ASSISTANT PHYSICIAN.

ACUTE ARTICULAR RHEUMATISM, URÆMIA AND MASTITIS—RECOVERY.

This case was that of a girl aged seventeen, by occupation a domestic. Has a decidedly hereditary tendency to phthisis. Never seriously ill before, but subject to colds.

Her present sickness began three weeks ago with two attacks of syncope, followed by a general soreness, and swelling of the ankles and knees, attended with pain and heat. Went to bed. Symptoms increased in severity and extended to all the joints in her body. There was fever, vomiting, profuse sweating, and constipation of the

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bowels. She had previously commenced coughing. Was put on treatment by her attending physician, with some relief.

When admitted she was fairly nourished but anæmic. Complained of general pain, more marked in her back and joints. The latter are swollen and their temperature is above normal. Temp. 104°; P. 104 and a little weak. No appetite, tongue coated, bowels constipated, not having moved for several days. Voice low and husky. Has a cough with thick muco-purulent expectorations, and pain along the sternum on coughing. Urine diminished in quantity, very acid, of normal specific gravity, and loaded with urates. Has profuse sweats and cannot sleep owing to the pains and a harrassing cough. Did not complain of heart, and on examination it was found to be normal.

The diagnosis of acute articular rheumatism was made, and she was put upon the following:

R.

Acid cresotinic.	ʒ ij.
Sodæ bicarb.	ʒ iss.
Aquae.	℥ iv.

M.

Sig. Tablespoonful every two hours. This was commenced at 7 P. M. The next day at 1 P. M. her temperature was normal and she said that she had slept well during the early part of the morning, felt better and only had pain on extreme motion. The day following her temperature was normal and she felt so much relieved that she asked to sit up out of bed, which she was not allowed to do. Treatment changed to acid salicylic ʒ ij. in the 24 hours.

The fourth day after admission she complained very much of headache and vertigo and would cry out when the slightest pressure was made on the right side of her chest. The nurse reported slight delirium at night. Stopped salicylic acid.

The next morning her temperature was 99°, pulse 96, and respirations 24. Was delirious last night and is slightly so now. Complains of pain over the entire body but especially marked on the right side. Speaks only in a whisper. Pupils normal. Right breast very painful, red and swollen as is also the surrounding tissue. Urine acid, 1.038 and contains 30% of albumen and some haematin. Ord. brisk cathartics, half drachm doses of potass bromid, and anodyne lotion to breast.

The following morning her temp. was 100° and her pulse 100. She had slept well and was quiet and rational. Has well developed mastitis of the right breast, without the formation of pus. This is the third attack of this kind that she has had during her present illness. The first occurred in the first week of the disease, and the second about ten days ago. No pain anywhere save in the breast, which was ordered to be poulticed, also ordered ʒ j doses of potass. bitart. every 4 hours. Takes more nourishment.

Two days later her urine was normal, and temp. 100°, in the morning. Sleeps and eats very well. Has no pain anywhere, Breast less swollen, red and tender; ordered, besides the potash.

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grs. ij of cinchonidia sulph. t. i. d. In a few days her breast had almost resumed its natural size, and was normal in everything else except color, which was rapidly becoming so.

This case is an illustration of the plan of treatment pursued in the first medical division of this hospital, in all cases of acute rheumatism. First the use of cresotinic acid for the immediate abatement of all the symptoms, which it seems to accomplish more quickly than any other remedy, including salicylic acid. The following recent case is a better example of this fact than the one above cited:

A man aged twenty-nine, entered the hospital about 3 o'clock in the afternoon; suffering with well marked symptoms of general acute articular rheumatism. Having had only nine hours sleep in eleven days, and it being his first attack. He was immediately placed on this plan of treatment. The next morning he reported that he went to sleep about midnight and slept till noon, when communicated motions did not make him wince. He went on to complete recovery of perfect health rapidly.

This acid is obtained from the same basis as carbolic and salicylic acids, viz. coal tar. Authorities say its antiseptic power is greater than the other acids mentioned in this category. Its greater remedial action in acute rheumatism I think will be fully demonstrated in a paper, soon to appear, comparing the results obtained by the use of these remedies in different cases, by another member of our staff. Perhaps its trial in some other diseases will show its greater efficacy than the ordinary methods now employed, and increase its reputation. It was introduced, as a therapeutic agent, into this country through the efforts of Dr. C. H. Lellmann, one of the attending physicians to this hospital. The great drawback to its more extensive use is the price, costing more than five times as much as salicylic acid.

To counteract the too great depressing effect on the heart, noticed as one of the results from the use of this remedy in some cases, we are in the habit, where it is thought to be necessary, of giving at the same time a few drops of the tr. digitalis with each dose of the acid, or when this action has been marked in other cases, it has been added to the treatment.

An interesting point in the first case, was the recurring mastitis, which is not a common concomitant of this disease.

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TRANSLATIONS.

DYSPEPSIA.

BY

DR. C. F. KUNZE. *

Translated from the German, for THE HOSPITAL GAZETTE.

BY

PAUL H. KRETZSCHMAR, M.D. OF BROOKLYN, N. Y.

Dyspepsia means " difficult stomach digeston" and is as such one of the most common symptoms of anatomical changes which have taken place in the stomach, but it is also a symptom of conditions *in which the normal structure of the stomach is not altered or in which, with our present state of knowledge, we are unable to detect any structural changes.* In the following pages this second form of dyspepsia only will be considered, and it may be stated here, that just in proportion as our medical knowledge advances, the number of cases belonging to this class will diminish.

Symptoms.—The patients complain, especially after taking food, and sometimes only after they have eaten certain articles, *of a sensation of heaviness and fullness in the region of the stomach.* Real pain is not generally experienced. Often there is a nausea, occasionally vomiting, the stomach is bloated, *in most cases the appetite is diminished,* and, sometimes, patients have an entire lack of appetite for any kind of food. Some patients have a remarkable desire for highly spiced articles. *The stomach digestion is much slower than normal.* Percussion shows the presence of undigested food a long time after nourishment has been taken. The patient feels weary, he has no desire for mental or bodily work and often complains of a very severe " compressing " pain in the forehead, and in the occipital region. If vomiting occurs, the food is thrown up, sometimes hours after it has been taken, in an undigested state. Not unfrequently it is saturated with foul gases, as the product of decomposition which has taken place within the stomach. If the quantity of gas present is at all considerable the stomach presents a bloated condition, known as *flatulence* and it attempts to empty its gaseous contents by frequent eructations (ructus). Sometimes the matter vomited is of an acid reaction, depending on the presence of butyric and acetic acids. The abnormal formation of acid also gives rise to an unpleasant burning sensation in the œsophagus and pharynx (Pyrosis). The tongue is no certain criterion, in some cases it is thickly coated, in others it is entirely clean. In cases of dyspepsia of

*The work from which this translation has been made is entitled " *Lehrbuch der Praktischen Medicin, mit besonderer Berücksichtigung der Pathologischen Anatomie und Histologie.*" Leipzig, 1878. It is a work which is considered by competent judges to be in many respects superior to Niemeyer. It was first published in Germany in 1870, and has since been translated into French, Italian, Dutch, and Spanish, and has reached its third edition in Germany. Several chapters of the translation are now ready for the press, and we shall present them to our readers as opportunity offers.

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short duration, caused by an overloaded condition of the stomach, or depending on the presence ot indigestable food, great relief, and often permanent cure is obtained by free emesis. Not unfrequently, however, vomiting does not occur, the ingesta are not thrown up, but enter the small intestines and produce pain, cramps, rolling, flatulence and either diarrhœa, or—as is often found among children—obstinate constipation. Among children such a condition is often followed by fever and restlessness at night, by increased frequency of respiration and pulse, and even by general convulsions which may prove fatal.

In *chronic cases* of dyspepsia, mental despondency and hypochondria are frequently developed: the state of the patient's nutrition becomes impaired, emaciation takes place.

The unpleasant sensations of fullness and pressure in the region of the stomach become permanent, and the patient complains about them even while the stomach is empty. At that time the symptoms frequently depend on a condition of chronic gastric catarrh, which often developes during the course of dyspepsia.

Etiology.—Dyspepsia,—derangement of the digestive function of the stomach without any known structural changes—depends either on *ingesta* ; or on *a disturbed condition of the general system ;* or on *altered innervation.*

I. *Dyspepsia ab ingestis* is caused ; (a.) by overloading the stomach with food, which by itself is not injurious, but interferes with proper digestion only by its *quantity.* To digest food properly, it is necessary that the quantity of food introduced stands in proportion to the digestive power of the stomach. If a larger quantity of food be introduced at once, the gastric juice is unable to digest all of it, the muscular action of the stomach becomes exhausted, the organ itself becomes debilitated, expanded, and the food remains longer in the stomach than normally.

(b.) By the introduction of articles, which are *indigestible.* All articles which cannot be acted upon by healthy gastric juice are to be considered as belonging to this class, viz : cartilage, tendons, tough meat generally, hard boiled albumen, etc.

(c.) By the introduction of articles, which either tend *to float away or to dilute* the gastric juice. Dyspepsia depending on this cause is often produced by drinking large quantities of cold or warm water in the morning—as has been recommended by Bock and others. To drink much cold water with the meals is not only injurious for its diluting effect on the gastric juice, but also because it diminishes the temperature of the stomach to such a degree as is incompatible with healthy digestion (Beaumont).

(d.) By the introduction of articles which influence the *chemical composition* of the gastric juice *unfavorably.* To this class belong all articles which prevent to a larger or smaller degree *fermentation,* viz : strong coffee, tea, alcoholic drinks etc ; all articles which are easily transformed into *acetic, butyric or carbonic acids* (carbo-hydrates) or those which are previous to their introduction into the stomach in a condition of *partial decomposition,* viz : sour milk, sour lager beer,

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mouldy wine, etc; or finally those articleswhi ch are *almost entirely decomposed*, viz.: old cheese, bad meat, etc. If the food, after its arrival in the stomach, cannot be digested properly, and especially if acetic and butyric acids are formed freely, the gastric juice itself becomes converted into acetic and butyric acid and a deranged condition of the digestive apparatus is developed, which is known under the name of "*dyspepsia acida.*" The secretion of these acids by the peptic glands themselves, as has been supposed in individual cases where their presence has been frequently observed, has not been proved physiologically. Conditions of the stomach peculiar to the individual have, however, a marked influence as to the predisposition to the formation of acetic and butyric acids from the food which has been introduced. This form of dyspepsia, due to the formation of acetic or butyric acids has nothing to do with an excessive formation of hydrochloric acid, which latter is a necessary constituent of the gastric juice and is *essential* for the digestion of food. It is a wide-spread mistake that the sour eructations of patients are due to the *excessive* formation of that kind of acid which enters into the formation of the gastric juice. The recent examinations of Leube and others show that stomach digestion depends on the presence of a certain quantity of hydrochloric acid, and that dyspepsia is much oftener caused by a deficiency of hydrochloric acid, than by an excess of it. Even in vomited matter of peculiarly acid smell hydrochloric acid is mostly wanting; the acid reaction being due to the presence of acetic or butyric, and not of hydrochloric acid. The question whether an increased quantity of hydrochloric acid in the gastric juice is injurious has not been determined as yet; it seems to me the only action it could have, would be to cause a too rapid stomach digestion.

Not unfrequently the gastric juice is observed to act in the contrary manner. It is sometimes of *alkaline reaction*, especially if large quantities of saliva are swallowed, as is found to be the case with great smokers or in cases of catarrh of the mouth and pharynx, gastric juice of alkaline reaction cannot perform its function and dyspepsia must follow.

II. *Dyspepsia depending on a deranged condition of the general system* is found to be present in *all diseases which are accompanied by well defined febrile movements.* Beaumont observed in such a condition the direct decrease and even the suppression of the gastric juice. It seems as if, in such cases, the more rapid retrograde metamorphosis depending upon the high temperature of the body, interferes with the production of gastric juice. Dyspepsia is frequently observed, and forms a very troublesome complication, in cases of rachtis, scrofulosis, arthritis and diabetes, as a more or less constant symptom of the deranged condition of general nutrition. The relation which dyspepsia bears to the diseases mentioned, is not altogether understood as yet.

III. *Dyspepsia depending on an altered condition of innervation* is observed in cases of hypochondria, hysteria, homesickness, neuralgia, etc. The secretion of the gastric juice depends just as much on the nervous influence, as the secretion of saliva and many other functions

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of the different organs. Cases of dyspepsia, following the continued use of opium or other narcotics, belong to this class, though there is in such cases a mechanical influence acting which should not be underestimated. From the use of the narcotics the peristaltic movements of the stomach become interfered with, lessened and sometimes lost altogether, food accumulates in the stomach, and not only causes a sensation of pressure and fullness, but also causes such conditions as were mentioned under "dyspepsia ab ingestis."

Treatment.—There is hardly any other morbid condition, where it is more essential to consider the *cause* of the disturbance than in dyspepsia. In a considerable number of cases the removal of the cause is followed by complete recovery, as may be readily seen in cases of "dyspepsia ab ingestis."

Aside from the detection of the cause of the functional disturbance, the regulation of the patient's diet is the most essential part of the treatment; permanent cure can never be brought about without it.

Generally speaking, the following rules in regard to diet in dyspeptic persons may be laid down:

I. *The patient's nourishment must consist of articles easy of digestion.* To this class of foods belong soups, prepared of starchy materials, beef tea,—provided it is not made too strong, and it does not contain much fat,—also milk, and especially buttermilk, raw or soft-boiled eggs, white of eggs hard-boiled are not nearly so quickly digested; furthermore, venison and the flesh of pigeons or fowls, some kinds of fish, smoked ham, if soft, white bread, etc. Of those articles which should never be served at the table of a dyspeptic person, the following may be mentioned: legumes, rye bread, cake, hard smoked ham, beef tea or any kind of meat with a great deal of fat, cheese, etc.

II. *Whenever the patient eats he should only take a small quantity at a time*, his stomach should never be entirely filled, he should never leave the table with feeling that his appetite is fully satisfied. To carefully regulate the quantity of food to be taken at one meal, is especially important with children, as they are, in most cases, entirely unable to judge as to the right quantity of food.

III. *The patient should only be allowed to eat again when the food taken before has been properly digested and left the stomach.* In adults, it takes from four to six hours for food of the average quality to be digested, in cases of dyspepsia it may require a much longer time. infants should never be nursed at shorter intervals than every two hours.

IV. *The patient should live on plain food*, high living must be abandoned, and but few dishes should be served at a meal. He should avoid taking supper late at night, and should not go to bed with a full stomach.

If the stomach is *overloaded*, some remedy should be employed which favors the secretion of gastric juice, and which retards the decomposition of food in the stomach. It is an old, and in most cases, a good custom, to take a small quantity of alcoholic stimulant just after finishing a rich meal. Unfortunately this custom is often abused, people think they have a right to overload their stomachs because

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they keep some good brandy in the house. Finally, the habitual overloading of the stomach, and the frequent use of alcoholic drinks, produce chronic gastric catarrh, often complicated by a catarrhal condition of the small intestines. It seems as if, after the introduction of very fat food, a small quantity of liquor assists in emulcifying the fatty material. The injurious habit of drinking large quantities of water must be abolished, and those who drink lukewarm water, fasting, to keep the bowels open, should consult a physician and leave it to him to correct the difficulty. I will only mention one instance which proves how much harm may be done by adopting the hydropathic method of regulating the movements of the bowels. Habitual constipation in females often depends on general anæmia; the use of warm water, or of other laxatives, while temporarily relieving the obstruction of the bowels, always increases the primary lesion, while some *light iron preparation* or the use of *Pyrmont water* frequently relieves the secondary difficulty permanently, by improving the quality of the blood.

If deficiency of hydrochloric acid in the gastric juice causes the difficulty, it is well to administer it (gtt. x: 120.0 (℥ iv.) aquæ; (℥ i) 30.0 syr. simplic. one tablespoonful every two hours). If the food has undergone fermentation, the decomposed material should be removed from the stomach, either by means of the stomach pump, which is the best way, or by the use of emetics or laxatives. After the organ has been cleaned, some remedy should be employed to prevent the fermentation of food in the stomach. I like the use of sulphite of soda (2.0 to 5.0: 120.0 aquæ, a tablespoonful three or four times a day) or 20 drops of benzine in sweetened water, per dose, or of creosote (gtt. vj: 120.0, sweetened water, one tablespoonful every two hours.

The catarrhal symptoms which are often developed during the course of dyspepsia should be treated according to the rules laid down in the chapter on chronic gastric catarrh.*

In *febrile diseases* we are but rarely able to treat the dyspepsia by itself, but the remedies which are to be employed against the principal disease should be selected with due consideration for the condition of the stomach. The physician should take care to select those pharmaceutical preparations which are easily assimilated. In cases of intermittent fever with dyspepsia, muriate of quinia is to be preferred to the sulphate of quinia on account of its being better borne by the stomach.

If the dyspepsia is due to *altered ennervation*, and if a so-called irritable condition of the stomach is present—persistent vomiting of almost all the food taken, a dislike to any kind of nourishment—the use of narcotics with the view of diminishing the irritability of the organ is indicated (morph. murias, aqua lauro-cerasi, tr. nuc. vomic.). The digestive properties of the gastric juice—which is secreted in diminished quantity—should be strengthened by the administration of small quantities of muriatic (hydrochloric) acid. Fresh mountain air, moderate out-of-door exercise, repeated full baths and other means

*Which we shall next present to our readers.—ED.

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to improve the general health of the patient, will assist in treating the gastric symptoms. Pepsinum porci in doses of 0.3 to 0.6 (5to 10 grs.) with or without hydrochloric acid, to be taken three times a day just before eating, is often beneficial. Iron should *not be given in any form* as long as the digestive power of the stomach is very low. If the functional derangement of the stomach is considerably diminished, light iron-waters, such as Pyrmont, Driburg, Schmalbach, Elster may be given, but care should be taken not to administer them at to early a period. Even with a moderate degree of irritability, the stomach cannot bear any of the iron preparations or iron waters.—The bitter tonics are suitable in cases of torpid dyspepsia; I prefer to give sweet flagg, calumbo, quassia, or tr. gentian. comp. If there is no desire at all for nourishment, and if all sensibility of the stomach has been lost, I have frequently obtained beneficial results from moderate doses of "fruit ice"—not ice cream—and from small quantities of very old strong wine, to be taken with the meals, In cases of "nervous dyspepsia", however, no positive rule can be laid down, which would answer for all conditions. Certain essential indications—the regulation of the diet, etc., always should be observed, but besides that, it is necessary to individualize each patient, and there is a large field left open for careful "trials."

The capricious stomach often cannot be controlled by the most scientific treatment, and the disease sometimes yields to the most absurd remedies.

PERISCOPE.

COLLABORATORS.

Dermatology:
HENRY G. PIFFARD, M.D.
Diseases of the Nervous System:
EDWARD C. SEGUIN, M.D.
Diseases of Women and Children:
FRANK P. FOSTER, M.D.
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Materia Medica and Therapeutics:
FREDERICK A. LYONS, M.D.
Ophthalmology and Otology:
SAMUEL B. ST. JOHN, M.D.
Orthopedic Surgery:
NEWTON M. SHAFFER, M.D.
Practical Medicine:
E. DARWIN HUDSON, JR., M.D.

ON THE PHYSIOLOGICAL AND THERAPEUTICAL PROPERTIES OF GLYCERINE.

Observations on the expired air after the administration of glycerine. By M. A. Catillon (Communication to la Société de Médicine Pratique). In a preceding communication M. Catillon established the fact that glycerine, when introduced into the economy, causes a notable diminution in the quantity of the urea excreted during the twenty-four hours, with a coincident elevation of the animal temperature ; at the same time the subjects to which it was administered increased in weight. Besides this he proved that it was entirely absorbed, that only a relatively small proportion escaped with the urine,

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the only means by which it was eliminated, and that notwithstanding this fact, it could not be found in the blood. From these facts he concluded that it served as an aliment in respiratory combustion, which consequently spared the fat and nitrogenized compounds of the organism. Thus he explained the augmentation in weight of those subjects who took glycerine, and also the diminution of the quantity of urea excreted coincident with the elevation of temperature. The combustion of azotized material was replaced by another combustion, that of glycerine.

But glycerine gives as the ultimate products of its combustion carbonic acid and water ($C_6 H_8 O_6 + 14 O = 6 CO_2 + 8 HO$) and we should therefore find a much larger proportion of these elements in the expired air after its ingestion, if, as he has said, it is burned in the blood in the same proportion in which it enters that fluid. Such was the question proposed to be determined in a series of experiments made in the laboratory of Prof. Vulpian, which gave the following results :

Glycerine administered to dogs, without food, caused an elevation of the proportion in 100 parts of carbonic acid contained in the expired air. This proportion which was about 4.3 per cent. before the experiment, became increased to 6 per cent. under the influence of a dose of glycerine corresponding to 3 or 4 grammes for every kilogramme of the animals weight, and to 7 per cent. under the influence of a dose of 6 to 8 grammes to the kilogramme. Not only was the increase in the carbonic acid shown in a proportion raised according as the dose of glycerine was augmented, but even, in the latter case, it was prolonged for a greater time. The increase commenced about an hour after the ingestion, reached its maximum 3 or 4 hours after, and lasted from 5 to 10 hours after the dose. After the ingestion of glycerine, the number of respirations remaining the same, their fullness increases, and the increase remains even when the proportion of carbonic acid has returned to the normal, probably on account of the exercise to which the organ has been put. This augmentation of the fullness of the inspirations did not increase with the dose taken, for it remained the same with doses increasing to 50, 100 and 150 grammes. At the same time that the proportion in every hundred parts was augmented the absolute quantity of carbonic acid gas exhaled increased in such proportion that, in this form, nearly the whole of the carbon contained in the ingested glycerine could be recovered. The absolute quantity of carbonic acid exhaled per minute, before the experiment, by one of the dogs was about 175 c.c. It was raised to 263 c.c. under the influence of a dose of 50 grammes of glycerine, and to 288 c.c. under the influence of a dose of 150 grammes. This increase of the carbonic acid after the ingestion of glycerine was equally well shown in dogs whose respiration was abnormal on account of affections of the respiratory organs. In one of these in whom pneumonia was recognized, the proportion of carbonic acid in 100 parts before the experiment was only 3.2, that is to say, very much below the normal average. It was raised after the ingestion of glycerine to 6.1. In an emphysematous dog the proportion of carbonic acid in

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100 parts of expired air was normal, 4.4 per 100; but the fullness of the respirations was small. After the ingestion of glycerine the proportion of carbonic acid was raised to 6 in 100 and the volume of expired air was found doubled, so that the absolute quantity of carbonic acid exhaled was considerably increased. The transformation of glycerine into water and carbonic acid takes place directly, for there was not found in the blood any of the intermediate products of oxidation: glycerine, formic, or oxalic acids. Numerous differences between the properties of glycerine and alcohol have already been pointed out. Contrary to the case of alcohol which M.M. Duroy, Lallemant and Perrin found was eliminated under its own form and which they found in the blood, the brain, and the liver, glycerine is not found in any organ and is eliminated almost entirely under the form of water and carbonic acid.—(*La France Medical*). F. A. L.

CEREBELLAR DISEASE.

Prof. Nothnagel of Jena, publishes a brief summary of the results of the analytical study of more than 250 cases of cerebellar disease. This communication is preliminary to the publication of a systematic work on localized encephalic lesions. His conclusions are: 1. Many cases of cerebellar disease—lesion limited to the hemispheric masses, not pressing upon subjacent organs—may run their course without definite or marked symptoms. Lesions which directly or indirectly involve the middle lobe of the cerebellum or superior vermiform process give rise to cerebellar ataxia. 3d. By cerebellar ataxia we are to understand a perversion of equilibrium closely resembling that observed in alcoholic intoxication, the patient titubates, stand with feet wide apart; if he be barefooted the toes are seen in active motion, and in walking, the body sways a good deal, the foot is brought down with ball or heel first, irregularly; closing the eyes sometimes makes standing and walking worse, sometimes not. In the recumbent position there is no ataxia. The upper extremities remain free from incoordination in the large majority of cases. 4th. N. does not think that there is a definite tendency to fall backward in cerebellar disease, as claimed by some authors.—*Berliner Klinische Wochenschrift*, 1878, No. 15. E. C. S.

PHYSIOLOGICAL ACTION OF ACONITE.

Dr. G. Hunter Mackenzie, in an elaborate article on "The Physiological Action of Aconite," now in course of publication in *The Practitioner* (March), sums up its action on the nervous system as follows:

1. It induces paralysis of the pheripheral sensory nerves, the sensory nerve trunks, and posterior (sensory) nerve-roots.
2. The irritability of the motor nerve is augmented.
3. The cerebro-spinal axis is variously affected, the functions of

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the cerebrum being unimpaired, the posterior (sensory) columns of the cord being also unaffected, and the anterior (motor) columns having their irritability greatly increased.

The action of aconite on the respiratory system is thus summarized :

1. Its effect on the respiration is primary, and due to the direct action of the drug on the sensory fibres of the vagus, and the respiratory centre.

2. It induces a series of symptoms closely resembling those developed after section of the vagi.

3. It causes death partly by asphyxia, and partly by the variety of collapse spoken of by Brown-Séquard as "characterised by a great diminution in breathing, produced by a peculiar influence on the central organs of respiration, the heart continuing to beat with more or less vigor." F. A. L.

NEWS ITEMS AND NOTES.

The Telephone and the Phonograph in Practical Medicine.—In a communication to the *Lancet*, a writer states his conviction that the telephone, combined with the phonograph, will become a necessity in clinical medicine, inasmuch as we have, in the phonograph, a means not only of registering sounds, but of reproducing them. "However much the telephone may be perfected for clinical purposes, it must always fail in transmitting sounds of the same quality as those received, consequently this defect will necessitate a special education of the ear to interpret the modified sounds. But with the phonograph sound vibrations can be made visible to the eye, registered on paper like pulse-tracing, and kept for future study and reference."

Dr. Stein, has recently invented a method of photographing the beats of the pulse. It consists in photographing a beam of light which has been passed through a perforated vibrating disk. The perforated disk is attached to the artery like a sphygmograph. A strong light passing through the hole in the disk is made to reach a sensitive plate, on which the movements of the disk are recorded in the form of a wavy line. This invention might be made available for registering the sound vibrations of the telephone ; for by attaching a perforated disk at right angles to the receiving telephone drum, the vibratious of the latter could be recorded.—*Scientific American.*

Poison of Snakes.—The transactions of the Royal Society contain a paper by Mr. Pedler, in which he publishes the results of his elaborate experiments on snake poison, which had for their object the discovery of an antidote, but which were unsuccessful. Ammonia, as an antidote for application to the wound, he has proved to be utterly worthless. Iodide of methyl and hydrochloric acid diminish the activity of the virus, and perchoride of platinum formed with it an almost insoluble and inert compound. Neither of these substances, when injected after the poison, proved capable of preserving life. In several instances, artificial respiration caused an apparent revival of

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life in persons and animals that secmed to be already dead, but in no instance did it avert the fatal issue.

A New Hypnotic.—Prof. H. C. Wood, Jr., has analyzed the seeds of *Sophora Speciosa*, a native plant of Texas, and has detected a new alkaloid, which he names *Sophoria*. Half of one of the seeds is said to be sufficient to produce delicious exhilaration, followed by a sleep lasting one or two days.

Oxygen in the Neighborhood of Vegetation.—Von Pettenkofer has demonstrated that there is no superabundance of oxygen in the vicinity of growing vegetation ; and that, as a matter of fact, so far as the supply of this gas is concerned, the country, with its boasted superiority, is not much better off than the city.

Hydrophobia from Cats.—A writer in the *Lancet*, states that it is a mistake to suppose that there is no danger in the bite or scratch of one of these animals. There have been abundant and melancholy proofs of the peril of contracting hydrophobia from cats ; and the danger is scarcely less than that which attends an injury inflicted by a dog.

Dr. Fordyce Barker.—This gentleman has been honored by having the degree of LL.D. conferred on him by Columbia College. The trustees could not have selected a gentleman better fitted or more worthy of this distinction, and we are certain that the numerous friends and admirers of Dr. Barker will feel as gratified as can he himself at this new mark of distinction.

Filiariæ in Drinking Water.—Cobbold, the eminent helminthologist, has demonstrated, by dissections of the mosquito, that from the blood of human beings it sucks filiariæ, deposits them in cisterns, wells,etc., and that these entozoa are received into the bodies of those who drink such water.—*Boston Med. and Surg. Jour.*

Women Doctors.—For the first time in Holland the degree of *Doctor of Medicine* has been conferred upon a lady, Miss Aletta Jacobs, who has announced her intention to practice medicine at Amsterdam.

Treatment of Diphtheria.—In our issue of May 2nd, page 246, we chronicled the success which had attended the treatment of diphtheria in a region of Rhode Island. We have since learned, through the kindness of Dr. Isaac Smith, Jr., of Fall River, Mass., that the preparation mentioned is a secret remedy which is lauded and advertised by circulars distributed to the public as " Dr. White's Specialty for Diphtheria." We had obtained the item from a highly esteemed and prominent surgeon of this city, who had evidently been imposed upon by the proprietor of this nostrum during a visit to this city. Under the circumstances, we must conclude that the statements made in regard to the efficacy of the preparation are entitled to no consideration whatever ; and must satisfy ourselves with having been the means of exposing the composition of such a nostrum.

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Erratum.—In the report of Dr. Little's lecture in the last number of the GAZETTE, page 272, in the list of materials used, insert "10*th*, *Protective oil silk.*"

Phosphorus as a Food for the Intellect.—In an article on the "Hygiene of Chronic Nervous Diseases," Dr. G. M. Beard, says: Although the generalization of Agassiz, that fish feeds the intellect, is among the wildest and most unscientific ever made, yet there is little doubt that the so-called "sea food," fish and oysters, is excellent for the nervous system, and very likely in part by virtue of the phosporus it contains; but it no more feeds the intellect than phosphorus given in any other way. A healthy brain and an intellectual brain are not synonymous. One may be perfectly well, and, at the same time, perfectly stupid; a fool may eat like a lower animal, while the great philosopher barely keeps himself alive. While food is essential to thought, yet the force in food is not converted into thought-force. Good thinkers, like good athletes, are usually liberal feeders; but thousand who eat as much or more, have very little intellect or muscle. The effect of a diet, largely of fish, seems to be sedative, calmative, like that of bromide of potassium, or phosphorus, or electricity—like these remedies producing dullness, rather than intellectuality, and inducing a disposition to sleep more than to think; not accelerating, but slowing down the wheels of the mind, and therefore excellent and adapted for the nervous, and overworked, and overworried.

Dr. H. T. Hanks has been appointed to the chair at Dartmouth, left vacant by the death of Dr. Peaslee.

Whooping Cough.—M. Dervieux believes he has found a preservative means in aconite, associated with ipecacuanha and cherry-laurel water. This mixture is either a veritable prevention, or simply an abortion. His formula is as follows:

Extract of aconite,	.05 grammes	=	$\frac{4}{5}$ grain nearly.
Cherry-laurel water,	4.00 "	=	1 drachm "
Syrup of ipecac	3.00 "	=	$\frac{3}{4}$ " "
Mucilage,	200.00 "	=	$6\frac{1}{2}$ ounces "

This is given as soon as the characteristic cough presents itself, in doses of a teaspoonful every hour to young infants; two teaspoonfuls to those more than three years of age; and a tablespoonful to adults every hour.—*Lyon Médical.*

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THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY.

A WEEKLY JOURNAL OF MEDICINE, SURGERY AND THE COLLATERAL SCIENCES.

EDITED BY

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H. H. KANE, M.D., Associate Editor.

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[The editors hold themselves in no way responsible for the views expressed by contributors.]

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EDITORIAL.

CHARLES G. POLK, A.M., M.D.,

Professor of Surgery in the Eclectic Medical College of Pennsylvania.

AND

LAMDON B. EDWARDS, M.D.,

Editor of the *Virginia Medical Monthly*.

versus

THE MEDICAL PROFESSION.

We had supposed, after all that has been said in the various respectable journals throughout the country, that no editor of a journal that had any claim to respectability would again permit any of Polk's contributions to appear in his columns. It seems that we have been mistaken, for the May number of the *Virginia Medical Monthly* has another of Polk's peculiar articles—a tissue of folly and trash, filled with advertisements of his own peculiar manufacture, and endorsed in a foot note by the editor of the journal.

We are naturally led to speculate upon the amount which was paid for the insertion of this advertisement in the reading columns of the

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journal. We cannot suppose that the editor inserted it without ample pecuniary consideration, as he must know that the admission of such advertisements will soon exclude all communications from respectable and intelligent contributors.

Dr. Sayre and the other contributors to the number containing this advertisement must feel highly flattered to be in Polk's company, and they will no doubt be highly instructed in "Infantile Innutrition," and may take lessons for their future correspondence. This method may pay Dr. Edwards well, it certainly degrades the journal and the contributors; and the profession, if it allows it to continue.

Dr. Edwards is the editor of a journal and necessarily sees all his exchanges; he therefore cannot plead ignorance of the degrading falsehoods of this individual.

In a previous number we gave positive proof that Polk was one of the professors, and sharers in the plunder of the bogus diploma mill, the American University of Philadelphia. Polk has since denied that he was connected with that or any other swindling shop. As further proof of the facts formerly presented we would say that we have lately found, under Polk's own hand, the following advertisement:—

"Prospectus.

Encyclopedia of the Science and Art of Surgery,

A Treatise on Special Therapeutics.

By Charles G. Polk, A.M. M.D., Phar. D.

Professor of Surgery in the Eclectic Medical College of Pennsylvania, and Professor of Materia Medica in the American University of Philadelphia.

Price $2.50. For particulars, address the author at——Catherine St., Phila."

We before stated all these facts, and proved them from advertisements in newspapers, which Polk denied. Here the fact appears under his own hand.

We need not recapitulate what has been said of this individual, suffice it to say that he has been characterized as "a fraud and a falsehood too evident to require further demonstration" by almost every respectable journal in the country. He even went so far in assurance as to threaten the editor of the *American Medical Bi-Weekly*, who gives him the benefit of an open letter, which he finishes in these words. "As Polk threatens to sue us for libel, he will find in this number a valuable amount of material to be used on that occasion. E. S. G."

We reiterate what we said in a former issue of the GAZETTE.

"After all there is some extenuation for Polk, there is little for Dr. Edwards. Polk has been in the habit of living by the same means, thinking in the same manner, making use of all that he can grapple into his net as the other members of the "University" have done, he is but following out his instincts;" but Dr. Edwards is disgracing himself, his journal, his contributors, and the profession. What can have induced Dr. Edwards again to change his mind? We have seen a copy of a letter from him to Polk in which he says,—"The evidence in

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regard to these matters has forced me to lose all confidence in you, and give no credence to anything you may have to say."

Dr. Edwards was also furnished with the following fact. "I can find persons who have seen his (Polk's) signature on a diploma of that college; which was sold to a picture dealer," so he "may amuse himself with the reflections that his immaculate journal has helped to give value and honorable standing to diplomas that are sold in the open market for what they will bring."

Dr. Edwards was very indignant with us for speaking plainly of the disgrace under which he put the profession by assisting such a brazen-faced imposter as Polk in his nefarious practices. We shall speak more plainly and appeal to the whole profession if Dr. Edwards repeats this insult.

LECTURES.

CLINICAL LECTURE ON PNEUMONIC PHTHISIS.

Delivered at the Pennsylvania Hospital,
BY
J. M. DA COSTA, M. D.,
Professor of the Practice of Medicine, in the Jefferson Medical School.

[Reported for THE HOSPITAL GAZETTE.]

L. M., 23 years of age, single, by occupation a sewing girl, was admitted to this hospital on the 19th of February 1878. She told us when she came here that she had already lost two sisters from consumption, but that she herself had always been entirely healthy until about a year before the time of her admission. She dated the beginning of her sickness back to a day when she became very much overheated and was immediately afterwards chilled through. Following this plain history of an acute beginning, came cough, pain in the right side, and fever. There was no spitting of blood at first. There was some loss of flesh, but according to the patient, neither the pain nor the loss of flesh were persistent symptoms. Five months ago the woman caught a fresh cold and since that time her monthlies have not made their appearance. Lately the loss of flesh has been more marked, and there has been greater depression and weakness than was previously the case. Even in the past five months, however, none of her symptoms have been as pronounced as might have been expected. Her case has been subject to very marked occasional remissions and exacerbations of intensity. Since she caught the second cold her cough has been more persistent and the sputa more abundant taking it all in all. Nevertheless, no one would suppose from outward appearance, that the girl was suffering from any grave disease.

Upon admission her temperature was 101°, her pulse 118, and her respirations 24. She was quite feverish. The patient was evidently, at the time, laboring under an acute exacerbation of the disease. Her urine was high colored, but the most careful examination failed to reveal the presence of any sugar, or of any albumen. Physical examin-

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ation of her chest very soon convinced me that there was a cavity of unusual size in the right lung. Anscultation revealed metallic respiratory murmur with occasional metallic tinkling sound. When the patient talked in a loud tone, or, better still, when she whispered, there was distinct amphoric echo of the breath sounds. These signs were conclusive in pointing to the existence of a very grave pulmonary lesion on the right side. The other lung at the time of first admission of the patient, was perfectly healthy, except at the apex, where the percussion note was duller than should be and the respiratory murmur somewhat harsh.

Of late, I have had occasion to remark once before, the girl has expectorated a great deal of muco-purulent matter, which is very frequently tinged with blood. The resident physician, Dr. Collins, says, that the sputa must amount to a pint or over in the course of the twenty-four hours. On some few occasions quite recently the matters expectorated have had an offensive odor.

We have treated the patient with cod-liver-oil, the syrup of the hypophosphites, small doses of arsenic, and plenty of good nourishing food, up to within the past week or so. Under this régime, she has shown the most extraordinary improvement. She gained five pounds in weight almost immediately, and began to look well and rosy. Her breathing became less oppressed and her fever went entirely away. Her temperature was steadily in the range of the nineties, never running above 99½°. Had any one of you gone into the wards at that time you would have asked, "What is this healthy looking, active girl, doing in the hospital."

This was the condition until about a week ago when she grew pale again and her temperature began to show a marked tendency to rise, mounting up, once, to 101°. There was still the most marked metallic respiration on the right side. The percussion note was, on the other hand, very likely to mislead one not trained in noting small differences of sound. It seemed of perfectly normal pitch, but upon comparing it with that elicited from the healthy lung it sounded amphoric, almost tympanitic in pitch. When the girl spoke in loud tones, or whispered, a distinct metallic echo could be heard. The physical signs, in fact, seemed to be much the same as those which were elicited at the date of admission, except that they were now and then obscured by a loose bronchial râle. The left lung still showed some dullness at the apex, with harsh respiration. While, however, the physical signs had remained almost entirely stationary, the rational signs had undergone a most marked exacerbation. The significance of the physical signs was undoubtedly that there was an enormous cavity In the right lung destroying nearly all of its tissue while the left lung was but little diseased. The cavity in the right lung is certainly the largest which has ever come under my notice.

The question now arises—how was this cavity produced? Is the case strictly one of gradual destruction of lung tissue, as in tubercular phthisis? I think not. I should rather ascribe the present condition of the right lung to a latent pneumonia which led in time to pneumonic phthisis. The lung was the seat of a cheesy degeneration, then

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there followed the breaking down of the softened lung tissue, leading to the formation of a cavity. The history of the case favors, I think this view—the acute beginning, the extensive disease of one one side of the lungs and the slight affection of the other side. The right lung to-day is almost liquified. We might, indeed, call this case one of pulmonary abscess were it not for the local irritation set up and for the very evident constitutional tendencies. The left lung is slightly tubercular at the apex. The right lung has been destroyed by a pneumonic action.

I want to call your attention to the great disproportion between the rational symptoms and the physical signs of the disease. I very often see just such cases as this one. Of course the physical signs disclose the true nature of the case and the true extent of the disease, but it does not do to base your prognosis upon the physical signs, in such an instance.

I desire to illustrate a very nice point of prognosis from this case. *In a case of pneumonic or tubercular phthisis, where the general symptoms are favorable i. e., are not grave, while the physical signs, on the other hand, point to the existence of very serious disease of lung structure, the prognosis will turn upon the showing of the general symptoms rather than upon that of the physical signs.*

To give more particular force and point to this general rule I would say that in this case the indications of general good health would lead me to say confidently, although the physical signs are such as they are, that the disease is likely to remain comparatively latent, that the fatal issue though certain is likely to be postponed for some time to come. *So long as the general health is comparatively good the lung disease is likely to remain, more or less, stationary.* The events of the last few days may change this present view of the case. If the fever and cough increase; and night sweating and dyspnœa, with general loss of flesh and strength make their appearance, I shall know that the tubercular disease of the left lung apex is increasing and of course modify my prognosis accordingly. At present (I wish you to understand me thoroughly) I say that the ultimate prognosis is bad, very bad, but that death, though none the less certain, may be more or less delayed owing to the comparative latency of the disease in the left lung.

How are we treating the girl. We have been giving her and we shall continue to give her until the temperature becomes normal, Niemeyer's pill, at least a pill resembling Niemeyer's, which we use at this hospital. This pill contains belladonna, digitalis, and quinia, but not any ipecacuanha. She takes this prescription thrice daily. It is already beginning to control the febrile manifestations. In addition to this she is taking inhalations of Lugol's solution (of the strength of M. V. to the ℥ j.) by the atomizer. When the Niemeyer's pill brings down the fever we will put the patient on cod-liver oil, the syrup of the hypophosphites, and arsenic, again.

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REPLY TO DR. S. B. ST. JOHN'S PAPER ON PLASTIC APPARATUS IN FRACTURES.

Delivered before the Surgical Section of the New York Academy of Medicine, May 14th, 1878,
BY
FRANK H. HAMILTON, M.D., LL.D.
Surgeon to Bellevue Hospital, Etc.,

[Reported for THE HOSPITAL GAZETTE.]

Mr. CHAIRMAN: the paper by Dr. St. John is such as I should have expected from him. It is full and complete and as impartial as ever may be properly expected from one who is defending his own views, but there are some points in which I cannot agree with the author fully, and especially as to the conclusions which he has drawn from the facts which he has gathered. It was many years ago that, when Mr. Radley announced that he had treated many fractures without apparel of any kind except an ordinary bandage, and that they were all "cured," that Mr. Johnson, the celebrated editor of the *London Medico-Chirurgical Review*, replied "that a cure took place we do not doubt, but the information we should most desire would be on the length of the cured limb, and on a few other matters of that sort," and at a later day the hospitals of Philadelphia and of Boston and of New York, furnished elaborate reports extending over a series of years, of the fractures of long bones treated in their wards, but in which nothing is said of the length of the cured limbs, and very little or nothing as to whether they were straight or crooked. The only apparent exception to this statement is found in the reports from the New York City Hospital made by Drs. Lente and Buck, respectively, in which they state the *average* results, but do not give the results in each individual case.

In 1853 Dr. Boardman, of Buffalo, published, under my supervision, nearly 400 cases of fractures of long bones which I had personally measured, and additional cases were published by myself, with measurements, in my report on "Deformities after Fractures" made to the American Medical Association in 1855-6-7. From that time I know of no similar tables which have been constructed until Dr. Sands made a report on certain cases of fractures of the thigh treated by plaster-of-Paris in Bellevue Hospital. This was followed by a paper by Dr. St. John, with reports of cases treated in the same manner, at Bellevue Hospital, and still later by papers by Drs. J. D. Bryant and Geo. A. Van Wagenen, the three latter gentlemen having been house-surgeons at Bellevue Hospital, and having obtained their principal experience in this form of dressing fractures at that institution. It may be stated that many of the cases presented in these four successive reports from Bellevue Hospital are enumerated more than once, and, without being so indicated, are comprehended more or less in the other reports; that is to say, the same cases have been repeated in the successive reports. These are all the reports up to the present time, of which I have any knowledge, at home or abroad,

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in which any attempt has been made to give the exact result in each individual case. It will be further noticed that with the exception of my own humble efforts, these reports have all been drawn from the records of Bellevue Hospital. (Dr. St. John corrected this statement of Dr. H. subsequently, by remarking that a portion of the cases presented by him this evening were obtained from other sources than Bellevue Hospital.—REP.) Dr. St. John has correctly stated this evening that statistics, in order to be valuable, must be made with care, and by responsible and experienced persons, and that otherwise they would be vitiated. Now, no one can appreciate more highly the scholarship and ability of the young men who constitute the house staff of Bellevue Hospital than I do myself; they have all undergone the most severe competitive examination for the places which they occupy, and a long personal acquaintance with them warrants me in saying that as finished scholars in the departments of medicine and surgery, they have no superiors in this country. All they lack when they enter the hospital is practical experience, and that is what they have entered the hospital to obtain.

Any one who has undertaken to examine the records of Bellevue Hospital in reference to the question of results in the treatment of fractures will observe a remarkable deficiency in this respect. It is only in relation to fractures of the femur that there has been in this regard a slight improvement, but in Dr. Frederick E. Hyde's tables, published in the *New York Med. Jour.*, Oct. 1874, including only fractures of the femur, 308 cases, being all which were treated at Bellevue, and found upon the records down to the year 1873, in 197 cases no mention is made as to the length of the limb.

That visiting surgeons who have no *special* interest in this particular question, should omit to make the measurements themselves, or to instruct their house-surgeons to record the same, is not strange: nor is it any imputation upon the faithfulness of the house staff that, under the same circumstances, they should omit to do so. The truth is, probably, that the house-surgeons themselves felt as little interest in the matter as did their chiefs, but, of the records which are made in these Bellevue Hospital books, it is fair to suppose that they were in general the results of the measurements made by the house staff and not their chiefs. This I have reason to know is often, if not generally, the fact. Now, are these records thus made by persons little interested in the question, and by persons inexperienced in measurements, such as we may be required absolutely to accept, and as authoritative? Not one of the four gentlemen who made the several reports from Bellevue Hospital already referred to, claim to have measured the limbs themselves, personally; nor would it be possible for them to state by whom the measurements were made, or even, probably, by whom recorded. Is it our duty then, in relation to a matter of science requiring so much experience and exactitude, to accept of these records as authoritative? Remember it is no longer a question of inches, but of lines. We have made great advances, as we believe, in the treatment of fractures, and especially of fractures of the thigh. The average shortening in fractures of this bone was,

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when my tables were first constructed, about three quarters of an inch, and many were shortened very much more. We know that we have reduced this average, and now we have come to the question of lines, as between the two or three plans which alone to-day retain to any extent the confidence of the profession in this country. I should be warranted, therefore, in rejecting all of these statistics as being placed in testimony against the statistics carefully made and recorded, of any man of recognized standing and authority in the profession.

But accepting Dr. Van Wagenen's tables as they stand, drawn from the records of Bellevue Hospital, and presented by Dr. Sayre as a supplement to his report on the subject of fractures made to the American Medical Association, I think in 1874, we shall observe that the results of the treatment of cases of fracture of the femur by plaster-of-Paris was by no means remarkably good. Dr. Sayre says in his report "Fractures of the long bones require that extension and counter-extension, under the influence of chloroform, or other anæsthetic, if necessary, should be made in a proper direction until perfect accuracy of adjustment is obtained, and after this, retention and fixation in this normal condition, until consolidation.

"By accuracy of adjustment I mean the perfectly normal condition of the bone as to length and position. When the extension and counter-extension have been properly made, the muscles and other tissues surrounding the bones will necessarily and positively force the fractured extremities into their natural position, as above described, unless some foreign body, as a shred of muscle or connective tissue, has got between the fragments."

Now, in the 32 cases of fracture of the femur reported by Dr. Van Wagenen as having occurred during the year preceding the report, and all of which were treated by plaster-of-Paris, according to the most approved methods known at Bellevue, the plaster being applied by experts, and some of which cases at least must have been in the wards of Dr. Sayre, there are 27 cases in which there is more or less shortening of the limb, one case in which the shortening is 1 1-8 inches, one in which the shortening is 1 1-2 inches, one in which the shortening is two inches and one with no union. It is apparent therefore, that in these 27 cases either the extension has not been "properly made," or the "retention and fixation" intended to be accomplished by the plaster-of-Paris has failed. The limbs are certainly not in their "normal condition." In the text of Dr. Sayre's report, the extreme shortening of the three cases is explained by the fact that these three patients "were necessarily confined to their bed on account of other complications," but the complications alluded to were delirium tremens in one case, pneumonia in the second, pleurisy in the third, neither of which would have interfered with a perfectly successful result in case Buck's extension had been employed. The only explanation of the case of non-union offered in the reports is that "the first splint was loose when removed." I would suggest whether an apparatus which will allow a limb to shorten two inches because the patient is compelled to lie in bed, can be supposed to have any power in itself to pre-

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vent shortening. How is it possible if the apparel has any secure point or points upon the surface of the body or limb for making extension or counter-extension, that while on, the limb should thus shorten? Is it not evident that the apparatus has left the limb to shorten as much as it was possible for it to shorten; even when no apparel is applied?

I shall deem it my duty now, gentleman, as in contrast with these records, to show you the results of the treatment of fractures of the thigh in cases in which I have had complete control of the patients from the beginning to the end of the treatment, and in which Buck's extension, or some modification of this method, has been exclusively employed. I have hitherto refrained, from motives of delicacy, from separating cases of fracture treated by myself from those treated by other surgeons. My tables have hitherto indicated only the average results obtained by other surgeons and myself conjointly. The first attempt which I have made to separate my own cases distinctly from the cases treated by other sugeons was in the last edition of my "Treatise on Fractures and Dislocations," in which I have tabulated 24 cases treated by myself with Buck's extension, and 30 cases treated by other hospital surgeons with plaster-of-Paris, all of which I had myself measured and examined. In this table it will be seen that in the cases treated by plaster-of-Paris there are five marked as bent or much bent at the seat of fracture, six as having anchylosis at the knee in various degrees, one with no union, one with paralysis and abscess of the leg, one resulting in gangrene, amputation and death. As to shortening: one is perfect, eleven are shortened over an inch (one being two inches shortened), fourteen at least an inch; while in my own table, 24 cases, every one is straight, there is no case of non-union, there is no case with anchylosis of the knee, there is no case of paralysis or abscess, there is no case of gangrene, amputation and death; six have united without shortening, only two with a shortening of an inch, four or five with a shortening of 3-4 inch or thereabouts, and the remainder less.

I have then been able to do better with Buck's apparatus than was done at Bellevue, according to the report of Dr. Van Wagenen, with plaster-of-Paris—very much better. It seems to me proper, however, in instituting a comparison as to the value of different methods, so far as the length of the limb is concerned, to the shaft of the femur alone, excluding extra and intra-capsular fractures of the neck, and fractures through the condyles. The successful treatment of both of these latter accidents depending less upon the apparel employed than upon the nature and complications of the accident. In the tables published in the last edition of my treatise will be found 13 fractures of the shaft of the femur treated by myself by Buck's and my own methods. To these I have now to add 4 fractures of the shaft treated exclusively by myself at Bellevue hospital, during the year ending January 1st, 1878, and contained in the papers which I now present to you, thus making in all a total of 17 cases treated in this manner by these methods by myself, of which six present perfect results; or, perhaps I ought to say, seven, inasmuch as one is shortened only the eighth of an inch, and I have been in the habit of con-

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ceding to others when the shortening did not exceed the eighth of an inch, that it should be recorded as perfect. Only four of the perfect cures were children under 18 years of age, not one is shortened over 3-4 of an inch, and the average shortening is less than two-eighths of an inch. All are straight. As to non-union, it has never occurred in a case treated by myself, by any method. I have never had ulceration to ensue from a dressing, and never had gangrene ensue, as a result of, or in connection with the treatment. This is my experience, gentlemen, with the method of treatment, which in the clinical lecture alluded to by Dr. St. John, I saw fit to recommend to the physicians and students who were in attendance, and it was because such results had not been obtained by the treatment with plaster-of-Paris at Bellevue Hospital, and elsewhere, where the cases had come under my immediate observation, that I felt it my duty to say that the plaster-of-Paris dressings, which had for several years been employed at Bellevue Hospital in the treatment of fractures of the *thigh* constituted a step backwards, and that I was happy to say that during the last year this method of treating these fractures had been almost entirely discontinued. The report made this evening by Dr. St. John, contains an enumeration of five or seven cases of terrible accidents under its use, namely, deep perforating ulceration, gangrene and death, all of which occurred in the space of a few years, and in the hands of admitted experts. I do not think, therefore, that Dr. St. John is authorized by the facts to condemn so pointedly, as he has done in the paper read to us this evening, my remarks made on the occasion referred to. I think they would have warranted me in saying much more than I did say as to the inefficiency and danger of using plaster-of-Paris in the treatment of fractures of the thigh.

From the 1st of January, 1877, to the 1st of January, 1878, 40 fractures of the thigh were admitted to Bellevue Hospital, and of these, only one was treated with the plaster-of-Paris dressing alone, from the beginning to the close of the treatment; 31 were treated exclusively by some modification of Buck's extension. 1 was treated on a double-inclined plan, the patient having a bent and anchylosed knee. In 3 cases, plaster-of-Paris was used from 2 to 7 days and then removed on account of its inadequacy or of the pain which it caused, and Buck's extension substituted. In the cases of two children, aged respectively 4 and 7 years, the first had been treated outside, with plaster, two weeks, and the limb was very crooked; extension was substituted, and the result was a perfect limb; in the second case, plaster-of-Paris was used alone, from the 10th to the 19th day, and then it had to be reinforced with a long splint. All these facts will be seen by a perusal of the following tables:

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TABLE No. 1.

9 Fractures of the Femur treated wholly in Dr. Hamilton's service in 4th Surgical Division at Bellevue Hospital, from Jan. 1, '77, to Jan. 1, '78. All simple Fractures. Prepared by W. S. Halsted, A.M., M.D., Senr. House Surgeon.

No.	Name.	Age.	Sex.	Point of Frac.	Treatment and Remarks.	Amount of Shortening.	Straight or not.
1	Mary Stafford..	75 y.	F.	Neck, Extra Capsular.	Buck's extension, with 8 lbs. for 3 weeks. After which, for 2 weeks nothing bnt a long side splint.	1 inch.	Straight.
2	Cath. McCland.	40 y.	F.	Neck, Ex Capslr.	Buck's extension, with 9 lbs.	½ inch.	Straight.
3	Wm. Williams..	11 y.	M.	Junction of Upper & Mid. thirds	Buck's extension. First 8 lbs. then 16, then 12.	None.	Straight.
4	Wm. Cole.....	46 y.	M.	Middle Third.	Buck's extension for a few days. Died on 11th of tetanus caused by a severe lacerated wound of the opposite foot.		
5	Isaac Curry....	5 y.	M.	Middle Third.	Dr. Hamilton's double, long splint for children, during six weeks, (union firm at 5 weeks) after that, for 2 weeks, silicate of soda; immovable dressing.	½ inch.	Straight.
6	Annie England.	53 y.	F.	Lower Third.	Buck's extension, 16 lbs.	⅛ inch.	Straight.
7	Ernest Schilatt.	34 y.	M.	Lower Third 2½ in. abv. knee jnt.	Buck's extension, 18 lbs. for six weeks, union then firm and plaster-of-Paris was applied for 2 weeks.	⅜ inch.	Straight.
8	Lavinica.	28 y.	F.	Left Lower ⅓.	Buck's extension, 10 lbs. United in six weeks.	Unknown,	Straight.
9	Griffin.			Right Lower Third.	Duck's extension, 10 lbs. United in 3 mos., was not firm until she left her bed and went about on crutches, without splints. This thigh was never as large as the left. It is now 1-16 of an inch the longest.	Unknown.	Straight.

This table is complete, so far as it was possible to ascertain the facts.

There are four fractures of the *shaft* in which the amount of shortening was ascertained, namely, Nos. 3, 5, 6, 7. In one, aet. 11 y., there is no shortening. In case 6, the shortening is only 1-8 inch, and this might properly be recorded as perfect. In the remaining two the average is less than 1-2 an inch. In every case the limb has united without a bend at the the point of fracture, and in the usual time, except in the case of one thigh, which was congenitally smaller than the opposite thigh. The 2 extra capsular fractures of the neck, have recovered in the usual time and with the usual shortening.

F. H. H.

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TABLE No. 2.

13 Fractures of the Femur treated in the two remaining services of the 4th Surgical Division, Bellevue, from January 1, 1877, to Jan. 1, 1878, prepared by W. S. Halsted, A.M., M.D., Senior House Surgeon.

No.	Name.	Age.	Sex.	Point of Frac.	Treatment and Remarks.	Shortening.	Strt. or not.
1	C. Daly	90 y.	F.	Intra-cap.	Buck's extension, with 6 lbs. for about two wks. Three pillows under the knee alone. Subsequently getting up and walking on crutches.	1 inch.	Unknown.
2	Dennis Kelly....	71 y.	M.	Extra-cap.	Buck's extension, 8 lbs. for 5 wks. This was the right thigh. Left broken at same point, (extra cap) 3 yrs. ago, and treated in this Hospital with plaster-of-Paris. The right thigh is ½ in. longer than left and straight, while the left trochanter projects very much.	Unknown.	Straight.
3	B. McCabe.....	70 y.	M.	Extra-cap.	Buck's extension, 16 lbs. 5 weeks.	⅜ inch.	Unknown.
4	A. Ahern.....	45 y.	M.	Upper Third.	Buck's extension, 18 lbs. This was a re-fracture.	1 inch.	Unknown.
5	Jas. Fitzgerald..	15 y.	M.	Junction Upper and Middle ⅓.	Buck's extension, 10 and 16 lbs. 7 weeks.	¼ inch.	Unknown.
6	James Marshall.	25 y.	M.	Junction Upper and Middle ⅓.	Buck's extension and Plaster-of-Paris, 4 or 6 weeks. Firm union finally. This was a compound comminuted fracture.	Unknown.	Straight.
7	James Thorne..	72 y.	M.	Junction Upper and Middle ⅓.	Buck's extension. Died 20 days after admission.		
8	Frank Pavesco..	50 y.	M.	Middle Third.	Buck's extension, 18 lbs., union delayed. Plaster-of-Paris. No union. Operation for ununited fracture. Death 5 mos. after receipt of the injury.	Not United.	
9	Louisa Peters...	2½ y.	F.	Middle Third.	Extension, 4½ lbs.	Unknown.	Unknown.
10	Michael Clark..	26 y.	M.	Junc. Mid. and Lower Third.	Extension with 28 lbs. then les.; no coaptation splints for 9 weeks, then Plaster-of-Paris and crutches. This plan of treatment is not in accordance with Buck's extension or any of its accepted modifications.	Not United.	
11	George Schlange	48 y.	M.	Lower Third.	Knee bent and anchylosed. Compelled to use a double-inclined plane.	Unknown.	Unknown.
12	Pat. Thomassy.	13 y.	M.	Shaft right leg.	Buck's extension.	Unknown.	Unknown.
13	Pat. Thomassy.	13 y.	M.	Shaft left leg.	Buck's extension. This leg the shortest after treatment. Both united.	Unknown.	Unknown.

In the above table all were "simple" except cases 6 and 7. Case 4 was a re-fracture, and cases 12 and 13 were at the same time in the same person—a double fracture. There are several omissions as to important points in this table, but they are as complete as a thorough examination of the hospital records could make them. The 1st case case 8) of non-union is supposed to have been due to a fragment of bone, found in the autopsy between the ends of the large fragments. The 2nd case (case 10) was not treated by Buck's extension, or by its modification, as used by myself.

F. H. H.

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TABLE No. 3.

Fractures of the Femur treated in the 1st, 2d, and 3d Surgical Division of Bellevue Hospital, from January 1, 1877, to January 1, 1878, collected and arranged from the records by G. E. Monroe, A.M., M.D., House Surgeon.

No.	Name.	Age.	Sex.	Point of Fracture.	Character.	Short.	Remarks.
1	H. Kearney..	40 y.	M.	Intra-cap.	Simple.	⅜ inches.	Buck's extension.
2	J. Meilan.....	50 p.	M.	Intra-cap.	Simple.		Buck's extension 1 week, plaster then applied and removed on account of pain, and Buck's extension resumed. Non-union.
3	M. Mallen....	30 y.	M.	Extra cap.	Simple.	1 inch.	Buck's extension.
4	Kelly.....		F.	Extra cap.	Simple.	½ inch.	Long side splint.
5	J. McCann...	59 y.	M.	Extra cap.	Simple.		Buck's extension.
6	J. Hardy.....	40 y.	M.	Extra cap.	Simple.		Buck's extension.
7	T. Carolin....	56 y.	M.	Upper ⅓.	Simple.	1 inch.	Buck's extension.
8	J. Berry.....	77 y.	M.	Upper ⅓.	Simple.		Buck's extension.
9	R. Norris.....	7 y.	M.	Junc. md. & Up. ⅓	Simple.		Plaster-of-Paris from 10th to 19th day, reinforced with a side splint.
10	P. Casey	51 y.	M.	Junc. md. & Up. ⅓	Simple.		Buck's extension 4 weeks, then plaster 3 weeks.
11	M. Boderiquay	28 y.	M.	Middle ⅓.	Simple.	⅜ inch.	Buck's extension 5 weeks, then plaster, which, causing pain, was removed, and Buck's extension substituted.
12	J. Furlong....	26 y.	M.	Middle ⅓.	Simple.		Buck's extension.
13	M. McCarthy.	4 y.	F.	Middle ⅓.	Simple.	Perfect.	Treated outside 2 weeks with plaster-of-Paris. Much deformed when adm'td. Buck's applied and kept on until cured. Result perfect.
14	J. Kling.....	40 y.	M.	Junc. Mid. & Lr. ⅓	Comminuted.		Buck's extension.
15	J. Meyer.	62 y.	M.	Junc. Mid. & Lr. ⅓	Comminuted.	⅜ inch.	Buck's extension.
16	W. Lust	31 y.	M.	Junc. Mid. & Lr. ⅓	Simple Transverse.	⅜ inch.	Plaster-of-Paris 2 days, then Buck's extension.
17	M. Rees.....	42 y.	M.	Lr. ⅓ ex. into jnt.	Complicated.	⅝ inch.	Buck's extension.
18	G. Kenser....	40 y.	M.	Shaft.	Refracture.		Buck's extension 2 days, then Plaster-of-Paris.

This table is very incomplete, owing to the imperfection of the Hospital Records, which have been examined very carefully by Dr. Monroe. F. H. H.

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One word with regard to the specimen sent to me by Dr. Gibbes, of S. C., and to which Dr. St. John has made reference in his paper. Dr. St. John thinks it is unfair to present this, in which there is a shortening of only ¾ths of an inch, the patient being 83 years of age, as testimony of the inefficiency of plaster, and that I ought not to have given it to the public in my treatise on fractures as testimony to this effect. I have, gentlemen, this specimen now in my hand, and it is my opinion, and you will examine for yourselves, to see that it is shortened more than three-quarters of an inch. Dr. Gibbes, as I have stated in my treatise, thought, from his examination before death, that it was not shortened more than three-quarters of an inch, but I stated in my report of the case that I thought it was more, and my opinion is that it is shortened an inch and a half. But my object in showing the specimen was, as there stated, to permit it to be seen that it shortened as much as it possibly could have shortened, and that the lower fragment, in its ascent towards the body, was only arrested when its upper extremity came in contact with the under surface of the neck of the femur, and that within these limits, whether it was three quarters of an inch or an inch and a half, the apparel had no power to prevent the shortening. The apparel was applied by a good surgeon, under chloroform and pulleys, as applied at Bellevue, within 15 hours after the accident, the patient being in robust health, and as soon as he was able to do so, he went about upon crutches. He died six months after the accident from apoplexy.

Dr. Hamilton then presented a photograph of a patient, Dennis Kelly, aet. 71, who, three years ago, sustained an extra-capsular fracture of the left femur, and which was treated at Bellevue Hospital by plaster-of-Paris, and who, October 30th, 1877, was admitted to Bellevue Hospital again, having, in consequence of a fall, sustained the same fracture in the right thigh. Buck's extension was applied, with 8 pounds weight. He is now walking about the wards of the hospital. his right limb being half an inch longer than the left, while over the left trochanter there is an ugly outward projection indicating that the fragments had been premitted to bend outwards, in this direction, while the form of the right hip is natural.

HOSPITAL RECORDS.

ST. FRANCIS HOSPITAL, NEW YORK.

Reported by, W. H. HAYNES, M.D., Assistant Physician.

MYELITIS.

The patient was a man aged thirty-six, whose father died of an attack of apoplexy. Habits temperate. Had gonorrhœa and chancroids fifteen years ago. Gives no history and presents no lesions of syphilis. Has always enjoyed good health, never having lost a day's work on account of illness. About the beginning of last November, he began to feel a degree of weakness and fatigue hitherto unknown

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and to enjoy a markedly increased venereal appetite. About the middle of the month he was seized with a severe pain and contraction in the right shoulder. It disappeared in a few days but was followed by severe pain in the same situation, unattended however by contraction, and wandering pains in his back and lower limbs. These became fixed and increased in severity. They involved all the extremities, were of a sharp, "drawing" character and were increased by motion. They all seemed to start from the back. Motion also provoked pain along the spine. These symptoms were attended by fever, loss of appetite and constipated bowels, but not by headache, sense of constriction in the chest or interrupted breathing.

A few days after the commencement of the sharp pains, he noticed a numbness in his fingers and toes that gradually extended and involved the whole of these portions of the extremities. After the sharp pains had subsided paralysis of voluntary motion appeared, which, together with paralysis of sensation gradually extended until the whole body was affected, save in the acts of defecation and micturition. His venereal appetite disappeared on the appearance of the acute pain and has not since returned.

About the middle of December he was able to sit up in a chair, but could not perform any voluntary act with the extremities. There was slight atrophy of the muscles. Sensibility and reflex and electric excitability almost *nil*. Morphine had to be used to give rest, there still being some pain. Appetite fair; bowels constipated. Temp. 103°F. Was put on gr's 10 iodid. potash and gtt. 30 tr. ferri mur. t. i. d. A gradual improvement was noticeable, the right side of the body advancing more rapidly than the left.

At the beginning of April, 1878, (the same treatment, with the addition of electricity for the past two months having been followed) his general condition was fair, although he was still weak. Motion had returned to all the muscles, but normal strength and rapidity were lacking; for instance, it is necessary for him to use his hands in order to rise from a chair. The grasp of his hand is little more than a faint pressure, and in walking he throws out his feet. He finds it necessary to look at the ground in walking and is unable to stand with his eyes closed. There is no atrophy of the muscles.

Sensibility as tested by the æsthesiometer is as follows:

LEFT UPPER EXTREMITY.		RIGHT UPPER EXTREMITY.	
Arm, external surface,	3½ inches.	Arm, external surface,	3 inches.
" internal "	2½ "	" internal "	2½ "
Forearm, flexor "	2½ "	Forearm, flexor "	2½ "
" extensor "	3¼ "	" extensor "	3½ "
Hand, dorsal "	2½ "	Hand, dorsal "	2½ "
" palmar "	1¼ "	" palmar "	1 "
Fingers, " "	½ "	Fingers, " "	½ "

Anterior surface of chest, on both sides 1½ inches.
" " " abdomen " " 2½ "

In the lumbar region and over the scapulæ 2¾ inches. In lower extremities there was a corresponding loss of about the same degree

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as in the upper. He can estimate and differentiate weights and temperatures pretty correctly. Electric excitability is still very much diminished, but is greatest in the flexors. Reflex excitability much diminished. No ataxia, cannot pain him by ordinary means, as pinching and pricking. Bodily functions well performed. Continues taking the iron and interrupted galvanic current, opthalmoscopic examination of the eyes shows them to be normal.

The absence of some of the characteristic symptoms of myelitis, and the favorable termination in this case can be accounted for, I think, by the rather mild degree of the inflammatory process, the onset and progress of which were gradual, and the acute symptoms of not long duration.

PERISCOPE.

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Diseases of Women and Children:
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SAMUEL B. ST. JOHN, M.D.
Orthopedic Surgery:
NEWTON M. SHAFFER, M.D.
Practical Medicine:
E. DARWIN HUDSON, JR., M.D.

ELECTROLYSIS OF SCROFULOUS LYMPHATIC GLANDS.

Mr. Golding Bird has contributed a paper on the treatment of scrofulous lymphatic glands, by the electrolytic caustic. He referred to the general disuse of caustic. He divided cases of scrofulous glands into three classes: 1. The glands free, though enlarged. 2. The glands matted together, or to the skin, or presenting hardened nodules, or encapsuled (lymphoma.) 3. The condition of active inflammation. The first-class was met by general treatment. In the second it was better to use the knife. In the third, the best operation was by caustic; and the least painful of any mode of applying it, was the one now described. A small arrow of sheet zinc, one inch and a half long, by half an inch wide, sharp at one end, had a copper wire ten inches long attached to the other. The other end of the wire was soldered to a plate of thin sheet silver or copper, three or four inches square: The latter was firmly strapped upon a piece of lint, wet with salt and water, on to the skin somewhere near the spot to be destroyed. Over it was placed some oiled silk or waterproof strapping. The zinc point was then thrust through the fungating mass to be destroyed; a small shield of gutta-percha, or cork, regulated the

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zinc point. Some cotten-wool and a bandage were placed over all. The gland was gradually disintegrated by the formation of chloride of zinc at the expense of the metal inserted, and came away in four to six days. When all the gland had come away, the wound rapidly closed, with very little scar. The lint must be wetted with salt and water, night and morning. Mr. Spencer Wells was employing this method for the removal of uterine cancer. He referred to two cases, in which, though the results were very satisfactory, much pain was complained of. In the latter, the total weight of slough was four hundred and thirty-three grains. He narrated the history of one case in which he applied the zinc in the form of a flat disc to necrosed bone with good result.—*British Medical Journal.*

TREATMENT OF URETHRAL FEVER.

Mr. Reg. Harrison of Liverpool, refers to the fact, that not unfrequently within a few hours after the passage of a bougie, the patient experiences a sense of chilliness; this rigor is usually followed by more or less febrile excitement, which quickly subsides, without causing the patient much inconvenience or distress; instances, however, occasionally occur, when similar symptoms prove to be of the gravest character; and are speedily followed by death. He records a case that fell under his notice, when death followed the introduction of a bougie in six hours and a half, such cases are no doubt due to shocke propagated by the sympathetic system, which largely supplies the generative organs. They rarely or never occur when anæsthetics have been used, thus suggesting that the consiousness of pain may be an important factor in their production. A practical deduction may be drawn, he suggests, from this, namely: That too large a bougie should not be forced into the bladder. Where he has reason to fear a rigor will supervene after the introduction of an instrument, he invariably prescribes a two minim dose of Fleming's tincture of aconite, to be given immediately after the operation. This he has found almost unfailingly effective. In the occurrence of a rigor, he generally uses quinine in 5-10 grain doses, combining in with aconite, when there are early indications of ferbrile excitement. In the management of suppression of urine, which more or less attends the severe cases, our efforts, be considers, should be directed towards securing the elimination of the excreta, which the kidneys fail to do. This may be accomplished by acting on the skin with vapour baths, or what is almost equally efficacious, by placing the patient in a hot bath, and then enveloping him in blankets. The infusion of digitalis, given frequently in teaspoonful doses, has been strongly recommended for its action on the kidneys when stimulating diuretics would be out of place.—*Lancet.*

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TREATMENT OF TRANSVERSE FRACTURE OF THE PATELLA.

At a late meeting of the Clinical Society, the president, Mr. George W. Callender, brought a patient fitted with an apparatus, which he had employed for some time past at St. Bartholomew's Hospital. It consisted essentially of a sheet of plaster, fitting to the thigh, and extending to the upper margin of the patella, with loops on either side of that bone, and of a canvas slipper between which, acting from the sole of the foot, and the loops in the plaster, such extension was made by means of pulleys as suffices to draw the upper fragment down to the lower portion of the broken bone. It was easy to regulate the tension, and when is was thought well for the patient to get up, the apparatus was left on, as it acted just as well when the man was walking about, as it did whilst he was recumbent in bed. Practically, the appliance had been found to insure very good results.—*Medical Times and Gazette.*

ABOUT BOOKS.

Landmarks, Medical and Surgical, By Luther Holden, F. R. C. S., from the Second English Edition. Philadelphia, Henry C. Lea, 1878.

In this compact little volume the author, so well known by every dissecting room student for his larger work on anatomy, endeavors to indicate those points on the surface of the body by which we recognize the position of organs, blood vessels, and so forth, that lie beneath them or in their vicinity. It is a capital idea and no doubt will be duly appreciated by many a student, and many a practitioner as well. The term *landmarks*, has been chosen to convey the author's meaning, and it does so admirably, as any one will appreciate who has been lost in an anatomical sea and suddenly recollects some saving guide that shows him where the land is.

It is needless to say that the author is accurate in description and full in detail, while at the same time he is concise.

The body is divided into sections and each considered separately and systematically. The head first receives attention, then the face. The neck, the chest, the back, abdomen, perineum, thigh, buttocks, knee, leg and ankle, foot, arm, forearm and wrist, and head follow in the order given. Then comes a short chapter on palpation by the rectum, and the book closes with a brief sketch of an examination per vaginam.

The work is one of great usefulness as a hand book, and will prove to be an invaluable companion to the busy diagnostician and operator, as well as one to be carefully studied and constantly referred to by the student.

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NEWS ITEMS AND NOTES.

Death from Carbolic Acid.—We take the following from the *British Medical Journal.* The case, taken in connection with the recent deaths from chloroform poisoning in the Insane Asylum, suggests the gross mismanagement and carelessness of officials in public institutions.

"We regret being called upon to record the death of a nurse in one of the Dublin Hospitals in consequence of her taking carbolic acid in mistake for wine. In the absence of any reported evidence as to whether the bottle was labelled or not, and as to the state in which the unfortunate woman was when induced to help herself to what, presumably, she mistook for a patient's wine, we would only remark that the carelessness of hospital authorities in general is painfully evidenced by this case. We have, over and over again, seen the undiluted acid, and strong solutions of it, left in unlabelled bottles in the wards of hospitals in reckless proximity with similar bottles or vessels containing medicines or stimulants. Mr. Shaw has shown (Journal, vol., ii, 1877, p. 638,) that out of a total of seventy deaths by carbolic acid poisoning he has noted, twenty were caused by taking it in mistake for medicine. When we consider that eleven of these twenty deaths occurred in hospitals and other public institutions, the responsibility that rests upon the authorities of such institutions should make itself felt. In all the deaths reported to have occurred in hospitals from this cause, it would appear that the nurses had free access to the strong acid and had mistaken it for wine or medicine. There is no reason why carbolic acid in its undiluted form should ever leave the hospital pharmacy. For no ordinary purpose is it necessary to have a stronger solution than a five per cent. one in the wards, and in the majority of cases in which the acid is employed, a much weaker solution will suffice.

Medical Uses of the Telephone.—We have already recorded various experiments and suggestions with reference to the medical uses of the telephone. It has been in use in the house of a medical man during the last few weeks, to enable a member of the family suffering from an infectious exanthem, to communicate with her family and friends, and this application we would recommend as very practical to the managers of fever-hospitals and asylums. In the *Boston Medical and Surgical Journal,* we read that its utility in the class demonstration of anscultative signs of disorder of the chest, is being studied, with good promise of success. Professor DaCosta made a preliminary trial in March last, at the Pennsylvania Hospital, of a Bell's Telephone constructed by Dr. W. B. Hopkins, a former resident. It was tested by cases of cardiac murmers and different varieties of respiration, and, while the results obtained weré not fully satisfactory, it was believed to be demonstrated that a slight modification in the construction of the instrument, enabling it to respond to more delicate impulses, would fit it for the purpose, and make it an almost indispensable adjunct to the clinical amphitheatre.

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Relaxation of Pubic Symphysis.—Dr. J. Braithwaite, related a case before the Yorkshire Branch of the British Medical Association, which occurred after delivery. Movement of the pubic bones upon one another could be felt by the hand, on presssng upward either thigh as the patient was recumbent in bed.

Dr. Brown-Sequard has been nominated Professor of Physiology in the College of France, in succession to Claude Bernard. Being, however, a British subject (born in Mauritius), he must be naturalized in France before his appointment can be confirmed.

Contagiousness of Phthisis.—Dr. Tappeiner, has proved by experiments in Buhl's laboratory, at Monaco, that phthisis is contagious. Mixing the sputa of consumptives with water, he caused five dogs to inhale the same in the form of spray. Two of the animals were also obliged to swallow a portion. After a lapse of six weeks the dogs were killed. They presented a general miliary tuberculosis of lungs, liver, and kidneys, and, in the two which had swallowed the matter, also, of the digestive apparatus. Carmine, which had been mixed with the inhaled liquid, showed that it had penetrated into the pulmonary cells. Professor Buhl established these results by making the microscopical examination. It is suggested that these experiments are an indication that the air of apartments occupied by phthisical persons, and not well ventilated may become dangerous to healthy persons living in the same quarters.

Two Remarkable Accidents.—The following notes we take from the *Scientific American*:—In the transactions of the medical society of New Jersey for 1877, Dr. Ryerson reports the case of a child which lived four weeks with over an inch of No. 1 sewing needle in the heart. Search for the needle before death was unsuccessful. At the autopsy it was found to have passed partially through the cartilage of the fourth rib, into the wall of the right ventricle. Pus welled up through the perforated cartilage, and loose, in an abscess holding an ounce or more of pus, in the muscular substance, lay the needle. It was supposed that until loosened by suppuration the broken end of the needle remained fixed in the rib, thus pinning the heart to the chest wall.

A still more remarkable accident, with recovery, is reported in the transactions of the medical society of Pennsylvania, for the same year. In this case a boy of fourteen was impaled on the end of a carriage shaft, the points of the shaft entering one inch below the left nipple and coming out at the back. The victim was swung three times into the air by the rearing of the horses, then pushed himself off, and walked home with some assistance. No cough or hemoptysis followed and apparently little shock, effusion into the pleura occurred with discharge of pus, front and back. This gradually lessened, and finally both wounds closed, the one in the breast last. The boy has recovered robust health.

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THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY.

A WEEKLY JOURNAL OF MEDICINE, SURGERY AND THE COLLATERAL SCIENCES.

EDITED BY

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LECTURES.

CLINICAL LECTURE ON INCONTINENCE OF URINE, AND ON SYPHILITIC MENINGITIS.

Delivered at the University Hospital, Philadelphia.

BY

WILLIAM PEPPER, A.M., M.D.

Professor of Clinical Medicine in the University of Pennsylvania.

[REPORTED FOR THE HOSPITAL GAZETTE.]

Incontinence of Urine.—This little girl is about six years of age. She is one of six children. Of these children three have died, and one has been affected in the same way as this girl. The mother died of consumption. This child has suffered from incontinence of urine ever since she was a baby. She wets her clothing at all times. You see how pale and delicate looking she is. By incontinence of urine we mean inability to retain the urine, which is discharged at all times

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unconsciously. This dribbling usually takes place at night—the bladder contracts and the contents are discharged. The discharge is not perhaps so much an unconscious as an involuntary act. Some cases of incontinence seem to be due to weakness of the sphincter—in still other instances it is the result of spasmodic contractions of the vesical muscles. It is sometimes difficult to distinguish between these two forms. Incontinence in children is generally dependent upon spasm caused by some local irritation.

The causes of local irritation are numerous. In treating a case the first thing to be done is to determine upon the cause. In certain cases the urine is exceedingly acid, containing a large number of crystals of uric acid. This over-acidity leads, of course, to irritation. In other instances, seat worms may be the cause of the disease ; in still others, it may be due to some irritation of the mucous membrane of the rectum. In many instances the cause lies in some defect of the nervous system ; a sort of chorea of the urinary bladder comes on. I think that there is some such nervous defect at the bottom of the vast majority of cases.

The treatment of incontinence varies according to the cause. If the disease is only dependent upon actual loss of power, the proper remedies are, of course, the bitter tonics, iron, etc. Minute doses of cantharides, strychnia and nux vomica do good as stimuli. Never subject the child to harsh threats, or brutal treatment. No child ever would do such a thing from mere naughtiness. The little patient should be spoken to kindly. Then proceed to treat the case in the following manner :

I. Remove the cause ; if it be over-acidity, by alkalies, etc ; if there be seat worms, give an anthelmintic ; if the digestion is at fault, rectify it by means of tonics, etc. II. Where the root of all the trouble lies in the spasmodic contraction of the muscles of the bladder, employ belladonna freely, push it up to its full constitutional effects. Gtt. v. of the tincture of belladonna, or from $\frac{1}{30}$ of $\frac{1}{16}$ a grain of the extract may be administered three times a day. The nervous tonicity should be brought up by means of the cold douche, tonics, and friction, and the bromides given in doses of 25 grains to quiet the local irritation. In the great majority of cases, if properly treated, the disease will, in time, disappear entirely.

Syphilitic Meningitis.—A. H., a sailor, resident of the state of Maine, 23 years of age. Was admitted on December 19th. Had swamp fever about two years ago. On November 28th, 1877, he was aloft in the rigging mending a sail when he was suddenly conscious of severe pains in his hips, knees and elbows.

Upon carefully questioning the man, I find that he had syphilis ten years ago, but that there were but few secondary symptoms.

After recovery from the attack of swamp fever there was, according to the patient, a partial anchylosis of the joints of the arms. The supra-trochlear glands were enlarged and the tissues indurated. In the man's hip also, just above the inguinal region on the right side, there was a very distinct hardness. Under anti-syphilitic treatment and repeated local blistering this induration was cured.

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While improving very satisfactorily, on January 16th, the patient was seized with a very sharp pain in his head and went to bed feverish and with furred tongue. His treatment was by the bromides and laxatives. These remedies doing no good he was at once placed upon the use of mercurials. On January 19th he felt dizzy, and, in the afternoon of that day, had a bad chill with a subsequent temperature of 101°. At that time, the exact diagnosis of the case was uncertain. The weather was then very damp and there was a good deal of malaria about. I thought the attack might have been an imperfect development of malarial fever. (I, even then, however, half suspected the existence of some intra-cranial syphilitic disease). Such being the case, it seemed strange that the treatment was so ineffectual. Then, again, it struck me that the disease, by reason of its gradual onset and peculiar symptoms, was not unlike typhoid fever. Upon this presumption, I thought it better to give it the benefit of the doubt and join full doses of quinia to the anti-syphilitic treatment, which consisted of gr. xv. of the iodide of potassium and gr. $\frac{1}{24}$ of the bi-chloride of mercury, thrice daily. The afternoon temperature still continued alarmingly high. On January 22nd the patient vomited twice and there was slight diarrhœa. On the 23rd there was retention of the urine for twenty-four hours, followed by delirium. The heart's action was much depressed, the extremities were cold and the man refused all nourishment.

The persistence of such symptoms after the continued and liberal use of quinia removed altogether from my mind the idea of malaria. I ordered the quinia to be stopped at once. Nor was it an attack of typhoid fever, for there were none of the characteristic symptoms. The belly was flat and not tympanitic and there was no eruption. On the 25th the pulse fell to 60 and became exceedingly irregular. It was then that I determined the case to be one of syphilitic meningitis with exudation exerting pressure on the cerebrum. The stupor, delirium and irregular pulse were at once made clear, as was also the immobility of the pupils and the elevation of temperature. I then increased the doses of the iodide and bi-chloride. To-day, I had the man's pupils dilated with atropia. The retinal circle was found to be greatly engorged—the margin of the retinal nerves showing the symptoms of incipient neuritis. This gave me full confirmation to my view of the case.

These cases of syphilitic origin are always to be dreaded. The characteristic symptoms are extreme headache and circulatory disturbance. The headache is sometimes fixed. Here it is in the occipital region. It is usually much more violent at night, as is the case here, and may be so marked as to give rise to pain upon pressure. Vomiting may, or may not be present. Vomiting is not so frequent in syphilitic as in tubercular meningitis. The bowels are generally torpid, or constipated. As the exudation goes on forming the pulse grows slower and the pupils respond but slowly to light. If the exudation forms rapidly the ophthalmoscope reveals distinct retinal disturbance.

Patients such as this one will die very soon unless treated efficiently

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and promptly by large doses of mercurials and iodide of potassium. The iodide of potassium may be given four times a day in doses running all the way from gr. xv. up to 3 j. The tolerance of this drug in disease of a syphilitic nature is extraordinary. I have seen patients take from 180 up to 240 grains of the iodide daily without showing the least symptom of *iodism*. The man's pulse has become much more regular since the quantity of the iodide was increased. His intellect is still very slow. You can sometimes produce the so-called "meningitic streak" in such cases as this one by drawing your finger sharply across the surface of the abdomen. This sign when present (it is slightly noticeable here) is of considerable diagnostic value.

CLINICAL LECTURE ON PERICARDITIS, AND ON FIBROUS TUMOR OF LIVER.

Delivered at the College of Physicians and Surgeons, New York,
BY
ALONZO CLARK, M.D.,
Professor of Pathology and Practical Medicine.
[Reported for THE HOSPITAL GAZETTE.]

This man, who is a bar-keeper by trade, gives us the following history:

Previous to his present illness, he was perfectly healthy and never suffered from rheumatism. About six weeks ago, he was seized with a sharp pain in the left side of the chest. It pained him quite severely to draw his breath. He had some febrile symptoms, and was in bed eleven days. At the end of that time, though still feeling the same distress, he got up and went out to get fresh air. This shortness of breath and severe pain has continued to the present time, and he cannot yet go up stairs without somebody to support him, while even then he is compelled to stop and rest every few steps. Previous to his present sickness, he was never short of breath. He cannot sleep for any length of time.

This history leads us to suspect pericarditis, though, usually, it is not a painful disease, and we do not often hear patients complain of such severe pains as this man tells us he has suffered. However, we will commence our examination with the heart. I do not observe any marked swelling of the precordial region though the left side of the chest is a little more prominent than the other. On palpation, we find the heart beat to be indistinct and the impulse quite feeble. On auscultation, we find that the sounds follow each other with considerable rapidity, but the sounds are quite indistinct. I do not perceive any murmur, although it might be present and I not hear it, for the normal sounds themselves are very indistinct. On auscultation, posteriorly, I discover nothing abnormal. I listen behind, because, once in a while, a large pericardial effusion presses the lung backward, and produces bronchial breathing by compressing the pulmonary vesicles. One of my friends once mistook a case of pericardial effusion of this kind for pneumonia, because he got bronchial breathing and dullness. In the present case, there is nothing of the kind.

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On percussion anteriorly, there is a pretty extensive region of dullness; it is not only dull over a large area, but it is quite flat in the central part of this region. The absence of impulse would lead us to the idea that there was no hypertrophy of the heart, yet the increased dullness would be in favor of it. There is, however, another explanation of the dullness, and that is pericarditis. Pericarditis would produce dullness in this situation, but it will also carry the region of dullness up as high as the second rib or the second inter-costal space. Let us then, ascertain this point more carefully. Towards the sides of the area of dullness, it reaches up to the second intercostal space, but in the center, it goes beyond this, up to the first intercostal space. You know that the pericardium, in extending on to the vessels at the base of the heart, forms a sort of pear shape, and when distended by fluid, the expansion takes place to a greater degree upward, in the center, than on the sides.

The patient, then, is undoubtedly suffering from pericarditis, with effusion, but there may be something else, as I infer from an abnormal fullness existing in the region of the liver. On examining that organ, we find that its area of dullness is not increased. The fullness begins on the left side and passes across the upper part of the abdomen to the right. There is a band of dullness which I believe is due to a distended colon, as it is situated over the position of that organ. On palpation, we feel a sort of pasty mass in which the fingers seem to make an impression. I think a dose or two of castor oil, or some other laxative, would relieve the condition.

I was myself, once, a laxative for a doctor who had a colon as big as my coat sleeve. I pressed my fingers into it and pushed along, thus starting the mass, and the result was more than a bucketfull of feces.

The only trouble then, appears to be a pericardial effusion, and no great amount of heart disease, if any. The most striking feature about the case is the amount of pain which, according to his story, has been very great. In nine out of ten cases the pain is not at all severe. There is quite a large amount of effusion present, and, as it has already lasted six weeks, I think it is going to be chronic, if we cannot call it chronic already.

As regards treatment,—I should try to get the kidneys to work immediately, and if we succeed the effusion may subside. If this means fails, we shall then have to draw the fluid off by puncture, through the pericardium. This is not a very old operation, and lately it has been successfully done a few times. It was usually reserved as a last resort, on account of the danger of wounding the heart, but in the present case, if we do not succeed in causing the absorption of the fluid in a short time, it would be quite justifiable.

The fluid is sero-purulent in character, in all probability. In acute cases we have no pus, but simply fibrin and serum. I once had a case, the record of which is in the New York Hospital, in which, on post-mortem, a gallon of fluid was found in the pericardium. I think it is the only instance in which so large a quantity has been found.

The right way for us to proceed in the case of the patient before

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us, is first to try diuretics, and then if we do not succeed, resort to puncture of the pericardium.

FIBROUS TUMOR OF LIVER.

The patient whom I now show you, says that he has been ill for some time, but continued to work up 'till about nine or ten weeks ago. About seven weeks ago, he noticed an enlargement in the abdomen, which was quite painful. He does not sleep well at night. He has lost all appetite, and says he is not able to swallow solid food. Has not been jaundiced. He has not been troubled with vomiting, only having vomited once, the matter ejected looking greenish, but not reddish or blackish. When he eats, it lies very heavily on his stomach, and he feels as if smothered, as he expresses it.

On examining the abdomen, it feels very hard to the touch, resisting like a board, just below the umbilicus, it yields a little, and there is a distinct edge to be felt. It feels lumpy, and there is at one particular point, on the left side, a mass, which seems to stand out distinctly. It is round, and about an inch or an inch and a half in diameter. It passes up and down with the breathing, showing it to be situated inside of the abdominal walls. There are smaller masses of the same nature in the neighborhood, but not many on the other side of the median line. The mass is lost under the ribs. Dullness on percussion extends up to the nipple. The mass measures 12½ by 10½ inches. The spleen is enlarged. The tumor is of course connected with the liver, as the line of dullness is continuous with that organ, and therefore there is nothing else that it could be connected with.

Only this morning I examined a child who had four omental tumors, and I concluded that they were omental, on account of a line where normal resonance was present between them and the liver. Here there is no such line, but the liver dullness is continuous.

The left lobe of the liver should extend normally, not more than four and a half inches to the left of the median line, while this tumor extends six and a half inches. The apex beat of the heart is quite distinct in its normal position, and strikes quite sharply against the wall of the thorax.

Now, the question comes up, what is this tumor? Of course it is hypertrophy of the organ, but with what? The lumps on the side might be one of three things, multiple abscess, carcinoma, and fibrous tumor. It is too large and hard for multiple abscess. They may be fibrous tumors, for they are hard, round, and stand out, and probably that is their nature. Real cancer has a cup shape, having a rim around and the border standing higher than the centre. I think, therefore, we have here fibrous tumor of the liver, with hypertrophy.

It is singular that there has not been more jaundice, but this shows that the duct has not been pressed upon. There is a slight tinge on the sclerotic.

The question next comes up, what can be done for this man? It is one to which it is difficult to find an answer. It is not likely that the iodide of potassium will do much good. You know it is often given to produce absorption, so we may try it. I should not have much

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confidence in derivatives, such as blisters. As to diet, he must take fluid nourishment. The best form usually, is milk, but milk contains a good deal of fat, and fat is not desirable. The liver would not, I think, grow so large, if no fat be taken; let him have the white of an egg, the yolk being discarded on account of its fat, beaten up with water and flavored. The juice of beef is another good thing. A common beef-steak chopped fine and pressed, would contain but little fat, while it would furnish a good deal of nourishment.

He complains of not being able to swallow solid food, but I cannot see why. The pressure backward and downward of the liver against the stomach, is pretty strong, and it is likely that pressure may be made on the œsophagus, and in that way prevent swallowing. I do not believe that there is a stricture, or much physical inability to swallow food, it is probably because the food disgusts him that he cannot swallow.

HOSPITAL RECORDS.

MOUNT SINAI HOSPITAL, NEW YORK.

REPORTED BY BENSON W. FELDMAN, M.D., HOUSE SURGEON.

PURULENT OTITIS—MENINGITIS.

B. M.,—aet. 26.—Germany,—S.,—Tailor. Has been ill for five days. His trouble began with a stitching pain in the left ear; on the second day he had pain in the left side of the head. Two days before admission to the hospital, the left ear began to discharge a thick yellowish fluid. *On admission* (*Jan. 6th*) there was a profuse discharge from the left ear, ordered syringing

Jan. 8th, 1878.—Applied tr. iodine freely to mastoid process.

Jan. 9th, 1878.—Ord. ferri. sulph. and potass iodid, internally.

Jan. 11th, 1878.—Severe and continual headache, ordered ice-bag to be applied to head.

Jan. 12th, 1878.—Headache relieved by application of ice, but returns if the bag is removed.

Jan. 14th, 1878.—Cutting pain from left mastoid process to middle of frontal bone. Hearing disturbed. Right ear, 20 inches, left ear, ½ inch.

Jan. 17th, 1878.—Ordered ammon. bromid., grs. XV t. i. d.

Jan. 18th, 1878.—Considerable pharyngitis, ord. astringents to throat.

Jan. 19th, 1878.—Trace of pus at external meatus, audit. applied blister to mastoid process.

Jan. 23rd, 1878.—Ordered potass. iodid, grs. V. t. i. d.

Jan. 28th, 1878.—Headache, Formication in left ear.

Feb. 3rd, 1878.—Sleeps well. No pain.

Feb. 4th, 1878.—Discharged, cured.

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CYSTOPLEGIA.

I. M.,—admitted Jan. 8th, 1878.—aet. 65.—Germany.—Wid'w'r.—*Diagnosis.*—Cystoplegia due to apoplexy. Has had cystitis for past ten days, and being unable to pass any water, has been catheterized daily. Urine, 1.026 alkaline. Thick, turbid, purulent sediment; ordered acid tannic grs. v. q. 3 hor., strychnia sulph. $\frac{1}{30}$ gr. t. i. d., and Faradic current to hypogastric region. Discharged cured February 15th, 1878.

PYÆMIC ABSCESSES.

I. K.,—Female.—aet. 32.—Germany.—Married.—Admitted July 19th. About three and a-half months ago a small abscess appeared on the posterior aspect of right thigh, and every few days others appeared in different portions thereof, up to about three weeks ago, when they opened at intervals of two or three days, and discharged coagulated pus. Since then they have remained open, gradually increasing in size. Have been painless during entire growth.

On admission.—(July 19th, 1877) inflamed, depressed, irregularly circular ulcerations with thickened everted edges, at above mentioned points; ord. unguentum hydrarg. oxid. rub. to right thigh, sol. Donovan to left and ol. morrhuæ internally.

Aug. 16th, '77.—Another abscess appeared about the middle of right thigh. Ord. tr. alœs co. internally.

Oct. 13th. '77—Temp. to date 99°–99¾°.

Sept. 13th, '77.—(12 M.) had an attack of syncope. Gave ether gtts. 30.

3 *P. M.*—Epigastric region very tender; ord. spts. etheris co. 3 j.

9 *P. M.*—Another syncope.

Sept. 19th, '77.—Temp. to date normal. Patient being chloroformed, the actual cautery was applied to each ulcer.

Sept. 20th, '77.—(A. M.) temp. 105°. Had a circumscribed erysipelas of left thigh. She was at once isolated, ordered, tr. ferri chloridi and quinia sulphat.

Sep. 28th, '77.—Temp. to date, 100°–103°–104½°. Erysipelas has entirely disappeared. Pt. feels quite well; ulcers healing rapidly.

Oct. 24th, '77.—Temp. to date, 99¼°–100°.

Oct. 31st. '77.—Discharged, cured.

FRACTURE OF DORSAL VERTEBRA.

E. P.,—Female,—aet. 22.—Austria,—single.—domestic.

Fell, three days ago, from a second-story window, striking upon her back on some sharp object. Was unconscious at the time of injury. No loss of sensation or motion followed. Suffered from retention of urine for two days; has passed considerable since yesterday.

On admission.—(*Aug. 2nd,*) absence of spinous process of last dorsal vertebra with pain at this point, increased by motion. Has had no stool for five day.

Aug. 9th.—No increase in lardosis. Ord. pepsine, gr. V. t. i. d.

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Ang. 14*th.*—Applied a water-glass, (silicate of soda) jacket. Had an attack of syncope while suspended. Gave spt's ammon. aromatic.

Aug. 15*th.*—Pain on micturition for past two days.

Aug. 16*th.*—Ord. nux vomica in addition to pepsine.

Aug. 21*st.*—Swelling at vulva, applied linseed meal poultice.

Sept. 5*th.*—Ord. kali iodid. grs. XXX, and unguentum belladonnæ to thighs, as upper part of both feel nodular.

Sept. 12*th.*—Small vascular growth at meatus urinarius. Vagina covered with punctate congestion and white flaky mucus. Uterus anteflexed. Has hysterical convulsions almost daily. Temp. always normal.

Nov. 4*th.*—Discharged, improved.

TRANSLATIONS.

CHRONIC GASTRIC CATARRH.

BY

DR. C. F. KUNZE.

Translated from the German, for THE HOSPITAL GAZETTE.

BY

PAUL H. KRETZSCHMAR, M.D., of Brooklyn, N. Y.

Anatomy.—Chronic gastric catarrh extends but seldom over all parts of the stomach; most frequently the pyloric end only is affected, not so often the fundus, and but rarely the part towards the cardiac orifice.

The principle changes which take place after the disease has lasted for a length of time consist: I., *In the change of the color of the mucous membrane.* Especially in those cases of chronic gastric catarrh which originate from a chronic state of passive hyperaemia, from a deranged condition of circulation, the mucous membrane is found to be of a dark bluish red color. This change of color may either be observed symmetrically distributed all over the affected parts or it may appear in patches. Occasionally small extravasations of blood are scattered over the surface. Instead of the evidence of existing hyperæmia, very often only the sequences of a previous hyperæmic condition are found; the color of the mucous membrane is very dark gray or even black from the deposit of pigment in the sub-mucous tissue, and into the gastric follicles. II. *Either in attenuation or in thickening of the mucous membrane and the muscular coat of the organ.* The attenuation occurs sometimes to a high degree, the walls of the stomach are smooth and pale, but covered to a large extent with particles of gray pigment.

The glands are shortened, their cells are small, and without the granular contents as usually found. The cavity of the stomach is very large and distended. Oftener than the attenuation of the muscular coat occurs thickening of the mucous membrane and of the muscular coat. Sometimes the thickening extends over a considerable distance, at other times it occurs on different places, and covers

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only small pieces of surface. The latter appears puffy, uneven, warty, (état mamelomé of the French writers) in consequence of the proliferation of the connective tissue, which pushes itself through "and grows pinlike between the numerous groups of gastric follicles" (Ebstein). Such a condition may be differentiated from folds which result from muscular contractions only, by the fact that these folds and wrinkles do not disappear if the mucous membrane be stretched. Sometimes in chronic gastric catarrh, the roughness of the inner surface of the stomach depends on the dilatation of the peptic glands, "the cells of these are filled—as is found also in acute gastric catarrh—with a large number of small granular albuminoid molecules of an opaque appearance" (Förster). Occasionally the thickening is due exclusively to the hypertrophy of the follicles, which form wart-like excresences, and generally appear in lines like palisades. (Polypoid catarrh). Such hypertrophied follicles may be easily mistaken for peptic glands. In rare cases small globular tumors are found, which are pediculated and situated on the mucous membrane. Klebs says that the largest part of these tumors consists of elongated glandular ducts with many ramifications, vessels of considerable size passing through in all directions. (Oedema of the stomach).

Cystic degeneration of the glands has also been observed, the individual glands being filled with a pulpy mass, and forming vesicles, rise above the surface of the mucous membrane. *The formation of erosions of any kind or of gastric ulcers, during the course of chronic gastric catarrh, is an exception to the rule.*

The thickening of the muscular coat depends on a simple increase in the number of the primative muscular fibres, as can be seen best after treating a specimen with chlorate of potash. Förster shows in his pathological anatomical atlas, a clear picture of hypertrophy of the muscular coat of the stomach. The picture shows very plainly that the ultimate cells of the muscular fibres—if the muscular coat of the stomach be thickened—differ in no respect from normal tissue, but they lie so crowded that it is only with great difficulty that they can be separated. The muscular hypertrophy is most marked at the pyloric orifice, gradually diminishing towards the cardiac end of the organ. At the former point the diameter of the muscular coat may be as great as 3 or 4 lines, and even more, and the formation of a stricture may be the result. The appearance on cutting through the diseased tissue, resembles very closely that of scirrhus. The different layers of the interstitial connective tissue, have on close examination, a fanlike appearance, and the resemblance may be considerably iucreased, if the submucous tissue has taken the characteristic features of fibro-cartilaginous tissue, and if the mucous membrane itself becomes hypertrophied. It has been claimed by different writers, that true scirrhus may develope from these scirrhotic conditions, but histological researches have failed to justify the statement.

Aetiology.—Chronic gastric catarrh is a disease which is very frequently met with, and statistics show that it affects males more often than females. The disease may develope itself from an acute attack, especially if the patient has been attacked more than once: or it may

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begin as a chronic affection. All causes which are liable to produce acute gastric catarrh, will bring on chronic gastric catarrh, if they act less violently but more constantly. Almost as a rule chronic gastric catarrh affects habitual drinkers and more especially those who have used alcoholic liquors for a long time. Next to this most fruitful cause of chronic gastric catarrh, is the excessive and continued use of all kinds of harsh drugs, a very frequent cause of the disease. Many of the gastric difficulties which are so apt to occur after a severe attack of some acute disease, are often due to a catarrhal condition of the stomach, produced by the administration of large quantities of medicines. Chronic gastric catarrh often depends on passive hyperæmia affecting the vessels of the stomach, such as occur in all disturbances which interfere with the freedom of the portal circulation. Of the numerous causes for the deranged condition of the circulation through the liver, may be mentioned, cirrhosis of the liver, consolidation of lung tissue, emphysema of the lungs and affections of the heart. And it is worth mentioning that in tubercular disease of the lungs, especially during the first stage of the disease, the gastric symptoms may present themselves so prominently, that it may be quite difficult to render the correct diagnosis. Chronic gastric catarrh accompanies always ulcerations, erosions and cancer of the stomach, and the subjective symptoms in either of these difficulties may be due to it only. Why it so frequently accompanies a condition of relaxation of the muscular coat of the intestines and obstinate coastipation—as found so often among females—is a question which has not been satisfactorily answered as yet ; and the same must be said in regard to the chronic gastric catarrh occurring in conjunction with rachitis.

Symptoms.—The examination for chronic gastric catarrh is best made after the patient has taken a full meal ; in such a condition all the local symptoms and signs are intensified.

In all cases of long standing it can be observed that the epigastric region is more vaulted and that the size of the stomach itself is enlarged. The latter may take place to such an extent as to enable the observer to recognize its exact shape and size on the surface of the abdomen. The percussion sound is generally dull over a considerable space, but it is normal in cases of short standing. The distention of the stomach is always in proportion to the size of the stricture at the pyloric end of the organ. The larger the stricture, the longer is food kept in the stomach, the more certainly will it undergo decomposition and produce foul gas. Of course in such cases where the stomach is expanded by gases, the percussion sound is markedly tympanitic and on palpation the stomach presents a peculiar resistance, simular to that of an "*air cushion*" (Bamberger). If on careful examination the contour of the expanded stomach has been marked on the surface with ink or nitrate of silver, it will be observed that after vomiting, when the stomach has discharged its contents, the size of the organ is considerably diminished and the epigastrium is sunken in. Another prominent symptom of chronic gastric catarrh is the sensation of fullness, tension and pressure on the stomach, of which the patients complain after eating. This unpleasant feeling generally lasts for from

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one to two hours, and is finally relived by frequent eructations. The epigastric region is tender, most markedly so over the pyloric end and over the small curvature of the stomach.

Women are often rendered unable to wear their dresses tight around the waist. The unpleasant symptoms in the stomach are increased by taking food in inconsistent form, while nourishment in the liquid state and easily digestible, generally agrees better with the patient. There are however, many exceptions to this rule and occasionly it even happens that articles which are generally considered quite indigestible, are well borne. In the intervals of meals the patients often suffer from severe heartburn. The appetite may be wanting altogether or the patient takes his food with disgust. Some patients experience a desire for highly spiced articles. It is well known that habitual drinkers eat but very little, but whatever they take must be "piquante."

If chronic gastric catarrh depends on the continued and excessive use of alcoholic stimulants, a catarrhal condition of the mouth and pharynx is almost constantly observed, and in the morning the roof of the mouth, the tongue and the teeth, are coated with a large quantity of phlegm, so much so that it is sometimes difficult to clean these parts. In this class of cases a condition is frequently met with, known as "Vomitus matutimus," which consists in vomiting of thin, watery substance, generally of alkaline reaction, early in the morning, while the stomach is empty.

This matter is made up of large quantities of mucus, a part of which has been swallowed during sleep, the greater part, however, originating from a hypersecretion of the mucous membrane of the stomach. Among temperate patients also, vomiting of large quantities of mucus often occurs. The matter which is thrown up, often contains the "sarcina ventriculi," a fungous growth, which is made up of quadrangular cells of slightly reddish-brown color, having somewhat rounded corners. Each of these cells is subdivided into 4 chambers by two lines crossing each other. These chambers sometimes contain a small nucleus. According to the examinations made by Itzigson, sarcina has it origin, probably, in a species of oscillarius, which grows as a green, velvet like turf in the wells of the country, being taken into the stomach with the drinking water.

The tongue.—is generally found to be coated and most markedly so in the upper third; this depends on the catarrhal condition of the pharynx which is found almost constantly occurring with chronic gastric catarrh. As a rule, the taste is diminished, but sometimes neither tongue nor taste are markedly effected. The movements of the *bowels* are rarely normal, if the catarrhal affection does not extend over other parts than the stomach, if, on the other hand, the disease is not limited to that organ but affects more or less the small intestines also, it is often observed, that several thin, watery evacuations take place early in the morning without repeating themselves during the day. If gastric and intestinal catarrh has lasted for some time, it is very apt to affect also the common bile duct, thereby producing a remarkable sallow look and the peculiar grayish-yellow hue of the face, which is so very characteristic among habitual drinkers.

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Natural History.—The course of chronic gastric catarrh always extends over a number of years, and temporary variations in the condition of the patient, changing between comparative ease and severe attacks, are very often experienced. Finally, the nutrition of the patient becomes impaired, he emaciates, mental depression takes place, and the prospects for final recovery becomes smaller and smaller. Especially if, in case of old drinkers, continued and considerable emaciation has taken place, it may be regarded as a valuable sign of the coming dissolution, it is only exceptionally that the physician's care and good management can prevent the fatal result.

In most cases dropsy occurs in the larger cavities of the body and through the areolar tissue, the patient's strength and vital powers diminish gradually, and death is taking place by asthenia. If chronic gastric catarrh be treated successfully—but the prospect of doing so is generally not favorable, except in cases of short standing; both primary and secondary assimilation gradually becomes more normal, the appetite increases, the skin loses its peculiar appearance, the mind brightens up, etc. But there always will be a disposition to the return of the disease, and some slight disturbing influence is liable to produce a new attack of the old trouble.

Differential diagnosis.—Often it is very difficult to distinguish between neuralgia of the stomach, gastralgia, and chronic gastric catarrh. In many cases the pain occurs in paroxysms only, or if it can be relieved by deep pressure, as well as by the introduction of a heavy meal, there can be no difficulty at all in diagnosing a case of gastralgia. At other times, however, gastralgia does not so clearly define itself. Pain does not attack the patient at regular intervals, but it may be continuous, changing only from time to time in severity, and pressure in the epigastric region may, just as in cases of chronic gastric catarrh, increase the suffering. This form of gastralgia is quite frequently found among females. If such a difficult case presents itself, the detection of the aetiology, the history and the duration of the disease, together with the experimental administration of certain remedies may be of great diagnostic value.

Habitual drinkers are properly classed among the subjects for chronic gastric catarrh, and if the patient belongs to that class, presenting also a catarrhal state of the mouth and pharynx together with intestinal derangements, the indications are strongly in favor of chronic gastric catarrh. If, on the other hand, the patient suffers from neuralgic pain in some other parts of the body, or if the nervous system generally is debilitated and irritable, as is found so frequently among hysterical females, and sometimes after great mental exertion among males, gastralgia should be suspected. Further, if, during the year the patient has painless intervals for a month or longer, and if afterwards the pain recurs daily, and if no mistake in diet can be detected, it is probable that the disease is of neuralgic origin. In cases of chronic gastric catarrh, well marked intervals of pain are rarely observed, *the patient has more or less pain all the time.* Another valuable sign for diagnosis is the final impairment of the nutrition, which follows gastric catarrh; people suffering from gastralgia hardly ever experi-

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ence the same kind of emaciation. In differentiating gastralgia from chronic gastric catarrh, we should never fail to consider the effect which the administration of stimulants has on the patient. Brandy, mustard, strong coffee and other articles of similar properties generally increase the difficulty in chronic gastric catarrh, but they often relieve the pain in cases of gastralgia. Exceptions to this statement however occur not unfrequently.

The differential diagnosis between chronic gastric catarrh and gastric ulcer, can be made only, if, besides the symptoms of the catarrhal condition, haematemesis has taken place at some time, indicating a solution of continuity. Without the latter symptom it may often be difficult and sometimes impossible to render a positive diagnosis. If haematemesis has occurred formerly, once or oftener, even if years have passed since, and if the pains are almost constant, being of a sharp, cutting, lancinating or compressing character, situated in the region of the epigastrium, inflammatory adhesions (peritoneal) in the neighborhood of the former ulcer should be suspected. A case of that nature occurred a short time ago among my relatives. Six years ago a man of 58 years of age had a copious haematemesis, no recurrence has taken place, but he suffers since that time almost constantly from very severe pain in the region of the stomach. These pains are so severe as to produce frequent attacks of syncope. In this case there is no reason to doubt that a former gastric ulcer has produced certain peritoneal changes, which are the cause of the patient's sufferings.

Chronic gastric catarrh should also be carefully differentiated from cancer of the stomach, and this too may often be quite difficult, except if previous haematemesis or a tumor felt in the epigastrium assist in arriving at the right diagnosis. Indeed, it is often observed that the subjective symptoms in a case of cancer of the stomach are identically the same as in chronic gastric catarrh. However, there are certain points, which carefully considered, will help to clear up the case. Patient's suffering from malignant disease of the stomach almost always die before the end of the second year. If the disease be of longer standing, its malignancy may be excluded on that account.

The state of the patient's nutrition is another valuable diagnostic sign. In cases of chronic gastric catarrh the condition of nutrition is moderately good for quite a period of time, and it is frequently observed that habitual drinkers—even those suffering from chronic gastric catarrh for some length of time, present a surplus of adipose tissue. If on the other hand cancer of the stomach is developing, emaciation in a marked degree takes place early in the course of the disease. The sallow, earthy, "cancerous" appearance of the patient, together with the peculiar, wrinkled condition of the skin, is so characteristic in its nature, that the experienced observer frequently suspects malignant disease without further evidence than the signs just mentioned.

Bamberger claims that sarcinæ found in the matter vomited, oftener indicate cancer of the stomach than chronic gastric catarrh.

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Treatment.—Only exceptionally can the cause of the disease be easily removed.

In some cases a common "cold" may produce a chronic gastric catarrh, and Trousseau has properly stated that chronic gastric catarrh may originate from a sudden change of temperature, or from exposure to cold and wet, just as well as a bronchitis, coryza, cystitis, endometritis, etc. He also states that this class of cases could not be successfully treated by the use of the mineral-waters of Carlsbad, Vichy and Plombieres, but by sulpher baths, hydrotherapy, and surf baths. We will add to this that patients suffering from chronic gastric catarrh, which was produced by such extrinsic influences, should pay a great deal of attention to their way of dressing. They should keep the body and more especially the abdomen warmed, and it is advisable for them to wear woolen bandages, so as to keep the stomach always covered. All cases of chronic gastric catarrh which originated from exposure or other influences of that nature, will be markedly benefitted by such means as produce a more active condition of the skin, viz., warm bathing, Turkish bath—or, if properly administered, diaphoretics. If the catarrhal condition of the mucous membrane of the stomach depends on an obstruction of the portal circulation, in which large class of cases the region over the liver is apt to be tender—cupping in the right hypochondriac region, leeches ad anum; blisters over the epigastrium and mild laxatives are indicated. If there is a disposition to rapid decomposition of food in the stomach, with frequent eructations of a sour taste, antacids should be employed, viz., carbonate of magnesia, calcined magnesia, lime water, bicarbonate of soda in small doses dissolved in sweetened water, or the alkaline mineral waters of Selters, Vichy, Bilin and Ems. Creosote is sometimes very beneficial; it may be administered in pill form or in solution:

℞ Creosoti, gtt. xij.
Succ. liquivit.
Pulv. rad. liquir aa 2.0.
M et ft. massa, et in pilul, No. xxx div.
S. one pill three or four times a day.

or ℞ Cresoti gtt. vj.
Syr. simplic, 30.0.
Aquæ purae 90.0.
M. ft sol. S. Tablespoonful as a dose.

In many cases of chronic gastric catarrh depending on causes mentioned above—exposure to cold and wet—good management and careful regulations of the patient's diet, will often suffice to cure the disease. The regulation of the patient's diet forms a most important part of the management of cases of chronic gastric catarrh, *but there are no rules which could be laid down, answering for all cases.* Very frequently it is found that an exclusive *milk diet* can be employed, as was first tried extensively and recommended by Kruckenberg. If this line of treatment be chosen, milk should be the patient's only nourishment for a length of time, and no food of any other kind should be administered. The milk may be given either fresh, boiled or not

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boiled, or sour, the cream being skimmed off, or in the form of buttermilk. Sometimes patients prefer milk soup, milk with rye flour boiled in it, and they may live on it for a long time. If milk disagrees with the stomach, or if the patient does not like to take it, the diet should be changed, and starchy food might be tried; the administration of this kind of food should never be continued for a long time. There is again a class of patients for which starchy food does not answer at all.

Not unfrequently articles of a more stimulating character agree better with the patient, viz. Caviar, salted sardines, smoked ham, good beef tea in small quantities, cold meat, especially young venison, or chicken, old Port and Burgundy wine in moderate doses.

Many articles are absolutely injurious, and among them are rye-bread, all kinds of cheese, potatoes, pies, nuts, salads of any kind, fat dishes—with the exception of fat fish. It is remarkable that fat salmon is generally borne very well. Of the fluids may be named strong coffee, lager beer, and especially alcoholic drinks, such as whiskey, brandy and rum. Good Rhine wine and Moselle agree with most patients and often have some beneficial influence over the disease.

In most cases it is necessary to watch the patients carefully, as most of them have to fight against old and bad habits, and they are so very apt to allow themselves deviations from the proper diet. Of the long list of drugs which have been recommended in cases of chronic gastric catarrh, the most prominent are: *subnitrate of bismuth, opium in small doses, and nitrate of silver.*

Among other formulae the following are frequently chosen.

℞ Bismuth subnitr, 1.0.
Sodae bicarbon, 1.5.
Opi. pulv., 0.1,
Sacch. alb. 2.0.
M. ft. pulv. et in chart, No. v. divid.
S. one powder, 3 times a day.

℞ Pulv. opii., 0.15.
Sacch. alb 2.0.
M. et ft pulv. et in chart, No. x, divid.
S. one powder, 3 or 4 times a day.

℞ Argent nitrat cryst. 0.2.
Succ. liquvit.
Pulv. rad. liquir, aa 9.0.
ut fiat massa et in pil, No. xx, div.
S. one pill 3 times a day.

Some practitioners give both the subnitrate of bismuth and the nitrate of silver in much larger doses, of the former 0.5 to 1.0, and of the silver preparation form 0.03 to 0.1 as a dose. According to my own experience, bismuth given in doses of 0.3 answers in the majority of cases, but occasionally a case is met with, where a larger quantity is indicated. Such small doses of the preparations of bismuth as 0.03—as were given formerly—are of no value. Frequently bismuth and opium are given combined and it seems to me as if the combination

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acts better than either of the two remedies used by itself. Nitrate of silver is as a rule only employed after bismuth and opium have been tried without success. Nitrate of silver given internally sometimes produces severe pain in the transverse colon, and is the cause of obstinate constipation, if administered for weeks and months, it may be followed by a very remarkable discoloration of the skin, (Argyria). This very unpleasant result of the long continued administration of nitrate of silver appears to many physicians as a warning apparition and prevents them from using this frequently very beneficial remedy. The fear of producing argyria is often exaggerated. It is of comparatively rare occurrence, does not make its appearance, always, even after long continued use of the silver preparation, and, even if it occurs, it shows itself very gradually first, as a few gray spots on the forehead and around the temples.

If, at that period, the remedy be omitted, and some strong salt water baths, together with purgatives be given, the deposit of pigment in the skin does not progress.

Of the different kinds of mineral waters, those of Carlsbad have the greatest reputation for their curative power over cases of chronic gastric catarrh. *Leegeu* formulates the indications for the use of Carlsbad water, as follows : "Carlsbad has proved itself the most reliable remedy in case of chronic gastric catarrh, *if there is considerable tenderness over the stomach*, if the sensation of fullness and of pressure is felt after each meal, and if highly spiced food or stimulating drinks, or fluids which contain much carbonic acid, produce pain and uneasiness. It is not a matter of importance which one of the different springs be used, *and the effect is equally good, whether the water be taken at the spring or at home.* Mühlbrunn, the water which is mostly exported, should be used in the following way : the bottle is placed in hot water and kept there until its temperature is raised to about 21½° C (70° F.) *Small quantities*—two or three wine glassfulls should be taken in the morning, fasting, followed by a walk of half an hour or an hour's duration. The bowels, which sometimes become constipated after the use of Mühlbrunn, should be regulated by the administration of some light laxative. An important part of the management during the use of mineral waters, is the regulation of the diet. *The patient must live on a small diet, and positively avoid all alcoholic drinks.*

After the continuous use of one of the Carlsbad springs for five or six week, the treatment may be omitted, but great care should be taken in *returning gradually* to a full diet.

The waters of Marienbad are indicated when the region over the stomach is not tender ; when obstinate constipation complicates the chronic gastric catarrh, as is found to occur so often among patient's living a sedentary life, when continuous backache, or a sensation of heaviness and fullness in the right hypochondrium exists, when there is some dyspnœa, and when dizziness in the head, together with other symptoms, indicate some obstruction in the portal circulation, or point to a condition of hyperæmia in the vessels of the spinal cord. The purgative effect of this water has a beneficial influence in depleting

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the vital organs. The patient should take one or one and a-half bottles of the water every morning, fasting, and always follow it by a long walk—five or six thin evacuations of the bowels are the general result.

If the patient is much emaciated, it may be necessary to combine with the mineral waters of Carlsbad or Marienbad some one of the springs which contains iron, (Elster, Pyrmount, Eger, Frauz, Spa, Driburg) or it may be advisable to give the patient the benefit of surf-bathing as a general tonic. At the same time, it is often indicated to employ the bitter tonics. (Nux vomic, tr. cinch. co., calumbo, gentian roots, etc.) Many practitioners like very much a combination of iron and quinia. I administer frequently small doses of quinia with iron in the following way:

℞ Ferr. carbonate, 0.3.
Quiniæ sulph., 0.02.
Sacch. alb, 0.6.

Dispens. tal. dos. No. xij, S. one ter. in die.

This iron preparation is easily digestible, and therefore well adapted for those patients whose digestive system is more or less deranged.

Another preparation which is valuable in cases of chronic gastric catarrh in anæmic patients, is ferr. sacchar. solub. Hornemanis, from 10 to 20 grains, to be taken 3 times a day.

PERISCOPE.

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DISLOCATION OF RIGHT THIGH UPON THE DORSUM ILII OF SIX MONTHS STANDING. DISLOCATION OF LEFT THIGH, WITH FRACTURE OF THE NECK AND NECROSIS OF THE HEAD; FALSE ANCHYLOSIS OF LEFT KNEE IN FLEXED POSITION; REDUCTION OF DISLOCATIONS; EXCISION OF HEAD OF LEFT THIGH, AND ESTABLISHMENT OF SERVICEABLE FALSE JOINT; EXTENSION OF ANCHYLOSED KNEE AND RESTORATION OF MOTION; CURE. BY PROF. GEORGE E. POST, M.D. —*Med. Record, May 11th*, 1878.

This is the somewhat elaborate title of a very interesting but very brief paper and which is farther illustrated by two wood-cuts. It is greatly to be regretted that in the report of a case so remarkable, there should be so little of detail as to circumstances and symptoms. A girl, aet. 13, had been pushed down, twisting her trunk and extremities in opposite directions as she fell, causing a dislocation of both

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hips, and a fracture of the neck of the left femur. An accident so unusual in the history of surgery, and especially in its manner of causation, would seem to demand some explanation as to the supposed mechanism of the accident, and a full description of the history from date of accident, of the signs upon which the diagnosis was made out; but upon these important points there is almost nothing except that her thighs and legs were strongly flexed upon her body and thrown to the left, that there was a sinus leading to the head of the femur on the left side and that the injury occurred about six months before she was seen by Dr. Post. The left head, being separated from the shaft, was removed by an incision. (It is scarcely proper to apply the term "excision" to this operation.) The anchylosis of the left knee was overcome by *brisement forcé*, causing much laceration.

Finally, the dislocation of the right hip was reduced, apparently with great ease, by manipulation, showing, as the writer says, "that bone-setting is a matter of address and attention to anatomical relations rather than of force."

Several pieces of necrosed bone subsequently escaped, her "general health" is now perfect, and she has very useful limbs. It is not said whether the wound has closed.

We deem it our duty, in calling attention to this interesting case, to make these criticisms upon the character of the report. We desire that our journal shall be a *reliable* record of *facts*, and it is due, therefore, both to the distinguished operator, and to our science, that a more complete account of the case be furnished before it shall be accepted as established in all the points assumed.

FRACTURE OF THE PATELLA. INJECTION OF ANIMAL MARROW BETWEEN THE FRAGMENTS. BY JOHN A. WYETH, M. D.—*Medical Record, May 11th*, 1878.

Dr. Wyeth, late demonstrator of anatomy in Bellevue Hosp. Med. Coll., and who is widely known for his valuable and original contributions to Surgical anatomy, has in this paper given an account of the successful treatment of an ununited fracture (a re-fracture) of the patella, made under very unfavorable circumstances. This is very difficult of accomplishment under any circumstances, and the profession will be greatly indebted to him for the ingenious apparatus which he devised for his patient, and which is explained by a wood cut

The injection of two drachms of marrow from the thigh of a sheep just killed. into the space between the fragments, was in imitation of the experiments of M. Ollier & Goujon, who found that "marrow transplanted into the muscular tissue will *frequently* generate bone." The results were negative, the union being fibrous, not bony. He rightly argues, however, that as the circumstances were exceedingly unfavorable, the failure in this case ought not to deter us from a repetition of the experiment in other cases. The injection caused no disturbance.

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NEWS ITEMS AND NOTES.

A Rebuke to Professional Newspaper Notoriety.—At the meeting of the Medical Society of New Jersey, at Spring Lake, N. J. on May 29th., a committee reported the name of Dr. Sayre for honorary membership, in recognition of his distinguished services in the profession. The report was violently opposed by Dr. Ryerson, who charged Dr. Sayre with having violated the code of ethics by having published his portrait and memoir some 15 or 20 years ago in the *Police Gazette* of New York. The report was accordingly recommitted, whereupon the committee, of which Dr. J. S. Green, of Elizabeth, Dr. Sayre's satellite and champion, was the chairman, resigned in a body. After the election of officers for the ensuing year, the vote recommitting the report was reconsidered, and Dr. Sayre was elected. Soon after this Dr. Sayre met Dr. Ryerson, and in his characterstic language, we are informed by the *Sun*, said "Dr. Ryerson, what do you mean by these charges? What you have said is unqualifiedly false and untrue. You have disgraced yourself, sir; and until you make an apology or prove *them*, either you or I *is* unfit to be a member of this society". To this mild language Dr. Ryerson replied, that the paper was handed to him in Dr. Sayre's office. Dr. S. then admitted that the portrait and sketch did appear, but without his authority, but that the paper was not the *Police Gazette*.

Dr. Ryerson deserves great credit for thus publicly challenging such newspaper notoriety and advertising as the above, and although he failed to prevent his society from sanctioning it, still he has succeeded in showing to the profession, one of the secrets of undeserved success, and has stigmatized the practice by having seven out of 38 votes of the oldest society in the country recorded against it. Although the record of these was subsequently expunged from the minutes, we record them here. The thanks of the profession are due to Dr. Ryerson.

Atropia vs. Opium.—Dr. J. Milner Fothergill recently restored to life a woman already *in extremis* from the effects of a large dose of laudanum by the injection hypodermically, of a full grain of the sulphate of atropia, the largest medical dose yet recorded.

Jefferson Medical College Hospital.—The Senate of Pennsylvania has passed the bill making an appropriation of one hundred thousand dollars to the Jefferson Medical College Hospital, which is the second appropriation of this amount to Jefferson. The University of Pennsylvania also tried for one hundred thousand dollars at the same time, but as they had already had two appropriations amounting to two hundred and fifty thousand dollars, the house refused to pass the bill.

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THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY.

A WEEKLY JOURNAL OF MEDICINE, SURGERY AND THE COLLATERAL SCIENCES.

EDITED BY

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EDITORIAL.

THE HYPODERMIC INJECTION OF MORPHIA.

A physician, at the present day, without a hypodermic syringe in his pocket, or close at hand, is looked upon as would have been a medical man fifty years ago, did he not own a lancet. In fact, in the comparatively short period of time that has elapsed since it first came into use, this instrument has advanced with wonderful rapidity in the general favor of the profession, it being now very extensively used.

As almost all disease, especially acute affections, have pain as a prominent symptom, and as the hypodermic injection of morphia usually produces a rapid and very agreeable cessation or amelioration of the distress, we are often led to administer the drug in this way, when it is not really necessary; the mouth and rectum being at our service. We do it, because having the instrument at hand, but little trouble is entailed, and we are pretty certain to give almost immediate relief, which, if the patient is suffering much, is what he wants, and

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which, if we accomplish it, raises us in his estimation. Then too, we are led on by the force of precept and example.

That this method of administering morphia is a valuable aid to the careful physician, there is not the least doubt, and that it is being used unnecessarily often, there is quite as little doubt. And further, that even in cases where its use was clearly indicated, when given in but small doses, and in the hands of very careful men, most distressing and even fatal results have occurred, has been proved beyond question.

In its favor we have the rapid absorption of the drug and its equally rapid action on the system in those cases where such rapid action is desired, also in cases where the stomach and rectum reject all medicine. Wood (Therapeutics, Materia Medica, and Toxicology, Phila., 1877, p. 218) says, "The advantages of the method are the quickness of the results and the increased power of relieving suffering, which the remedy seems to acquire * * * * * * but it must be borne in mind, that sometimes they cause most unpleasant results. I have seen very alarming results from the injection of the one-sixth of a grain, and half a grain has produced death. In females, unless very robust, the maximum dose should be one-eighth of a grain ; in men, one-sixth to one-quarter."

These are strong words, and, though they bear their meaning plainly on their face, are disregarded by fully one-half the profession. That deaths every now and then occur in this and other cities from such disregard, is undoubtedly true. That this is the case here, we are assured by a very prominent medical gentleman, professor in one of our colleges, who says that he has been present at several autopsies where morphia, given in this way, was the undoubted cause of death. Dr. E. Fletcher Ingals, in an able and well grounded paper in the May number of the *Chicago Medical Journal and Examiner*, calls the attention of the profession to the danger of administering morphia in this manner. Of fifty-five replies which he received from circulars sent to prominent physicians of the Northwest, thirty-four said they had seen no unpleasant effects whatever ; six saw nothing more serious than abscesses at the point of injection, and the remaining fifteen all noticed bad results in some cases, death occurring in seven instances from this cause. Dr. Ingals vouches for the good standing and veracity of the gentlemen who reported these cases to him ; he withholding their names "for obvious reasons."

In two of the fatal cases the amount of morphine given was not stated. In one of two cases reported by one man, death resulted from the hypodermic injection of one-fifth of a grain of morphia, combined with one-seventy-fifth of a grain of atropia. "Another reports two deaths : one, from two doses of morphia, of one-third of a grain each, with an interval of four hours between the first and second doses. In this instance the morphia was given to relieve the intense pain attending invagination of the intestines. Death from narcotism ensued six hours after the second dose. The other death reported by this physician, resulted from one-quarter of a grain given in a case of sciatica. The patient died comatose within five hours. Another

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reports a death caused by two doses of one-quarter of a grain each—the first given internally."

In another case, a woman upon whom ovariotomy had been performed, death resulted from two doses together, amounting to one and one-half grains, (uncertain) an interval of five hours between the doses. In from fifteen to twenty minutes after the last dose, profound narcotism showed itself, and the patient died in two hours, although the most approved treatment was tried. Another case is reported where the patient, suffering severely from myalgia, was first given one-sixtieth grain atropia, and no amelioration following (although the physiological action of the drug showed itself), one quarter grain morphia was injected, followed in about three-quarters of an hour by one-quarter grain more, as the man was still groaning with pain. In about two hours the patient was found to be deeply narcotized, and, although everything possible was done, he died twelve hours after the last dose of morphia.

Many others, though not recording deaths, bear emphatic testimony to bad results, such as syncope, general numbness, prolonged sleep, (twenty-four hours in one case where the one-twelfth of a grain was given) etc., etc.

Many of us have resorted to this form of administering morphine almost every week, some oftener, and never having had any bad results, feel that in *our* hands, at least, no accident could happen. Although the feeling is natural, in the face of the facts given, it partakes more of egotism than of common sense. As the constitutions and conditions of our patients vary, so will the danger vary.

Even if this method of administering morphia was entirely without danger, and the cases reported by Dr. Ingals fabrications, or deaths from other causes, there is no reason why the drug should be given in this way, in cases where the mouth and rectum offer good absorbing surfaces. As we have said before, where there is a call for rapid absorption, and rapid and powerful action of the drug, or when the stomach and rectum are so conditioned as to render the use of the morphia in that manner impossible or unsatisfactory, then its administration hypodermically is called for, and only then.

We are told by several of the visiting physicians to our hospitals here, that they are firmly convinced that the hypodermic injection of morphia is carried to excess both as to the number of cases in which it is given, and in the doses administered. A physician of good standing in this city was heard to remark not long since that when "called to a case where he was puzzled as to diagnosis or treatment, he gave a stiff hypodermic of morphia, and awaited developments." Is it then any wonder that the opium habit is so common? In these days of hurry or bustle we often fail to consider the remote as well as the immediate effects of potent drugs on the human system.

Two of Dr. Ingals cases show very plainly that the combination of atropia with morphia is no safeguard against the occasional evil effects of the latter; and further, that morphine cannot, as many suppose, (hypodermically at least) be given freely during pain, in the belief that the drug is used up in combating the distress.

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Any gentleman who has used a hypodermic syringe very much, will testify to the fact that there are few instruments as liable to get out of order as this. Moreover, the comparison of a number of syringes by different makers, and by the same maker, demonstrates the fact that not only does one vary from another in the amount contained, for the same markings on the barrel or stem, but that some contain less by five or six minims than the amount marked on the indicator.

The subject of the hypodermic injection of morphia is one well worthy the study of the profession, and if the few facts and observations here recorded shall lead others to give the subject a fuller and more careful consideration, we shall feel well satisfied.

LECTURES.

CLINICAL LECTURE ON AORTIC AND MITRAL REGURGITATION.

Delivered at the Philadelphia Hospital.

BY

JAMES TYSON, M.D.

Professor of Morbid Anatomy and Pathology, and Lecturer on Physiology in the University of Pennsylvania Medical School.

[Reported for the HOSPITAL GAZETTE.]

AORTIC REGURGITATION.

I. M.; 40 years of age, engineer; born in Ireland; admitted to the hospital on July 19th, 1877. Family history good. Had been much exposed to extremes of heat and cold; had syphilis several years ago, (syphilis is a very common cause of valvular disease of the heart) and has always been a hard drinking man. He was perfectly well up to the year 1874, when he had an attack of hemiplegia of the left side without loss of consciousness. In two months after this attack he was well enough to walk about, but did not recover the use of his arm. On February 9th, 1876, he had another attack, on the left side; two months later his right leg was affected. Throughout all this time his right arm was never touched by the paralysis. Two months ago his intellect was temporarily lost, and still later his legs began to swell. To-day his mind is entirely normal, but he has paralysis of the sphincters causing incontinence of urine and fæces. Sensation is present in all of the paralyzed limbs (both legs and the left arm), but is somewhat imperfect. The urine is slightly albuminous and contains triple phosphates, oil casts, and granular epithelium.

As we consider the man's past history to-day as sketched out above we find nothing which points to cardiac disease except the swelling of the legs some weeks ago. He was a very ill man indeed when I took charge of him at that time. Now the swelling has altogether gone except in his feet. I find to-day that his feet have almost regained their normal size. When he first came into my wards he could not

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lie down at all, now he is perfectly comfortably in the recumbent position.

I propose to make a thorough physical examination of the patient in your presence to-day.

Pulse.—84 to the minute, volume good but soft and compressible.

Heart.—Upper border of heart's dulness is found to be in the third interspace. In health it is the fourth interspace, or over the fourth rib. The right lateral border of dulness is a little to the left side of the sternum; normally it is at the junction of the costal cartilage with the sternum, we cannot therefore say that the area of dulness is much extended towards the right. The apex beat is just below the left nipple—it should be an inch below and to the right of the left nipple. The heart is therefore pushed over to the left, there must consequently be some hypertrophy of the left ventricle. So much for the percussion signs.

Upon careful anscultation, I hear, placing my stethoscope over the mid-sternum, two murmurs, one systolic and the other diastolic. At the apex the heart sound is not as distinct as it should be, but the first murmur has entirely disappeared and the second murmur is only heard faintly. This persuades me that there is no mitral disease. I now place my stethoscope over the site of the second costal cartilage on the right side, the aortic cartilage. Here I can easily distinguish a very clear sound. This murmur is carried up into the carotids, and intensified when the man stops breathing. This murmur must be aortic, it is during diastole—during the diastole the auriculo-ventricular valves are open and the aortic and pulmonary sigmoids are closed. Evidently this diastolic murmur can only be due to insufficiency of the aortic leaflets—a small amount of blood regurgitates with each closure of the valves.

But is this all the trouble? I am not so sure about that at present, before the class, I am unable to make out any other abnormal signs. I am, however, from examinations made in the quiet of the ward, inclined to believe that there is some aortic stenosis. I heard a systolic aortic murmur yesterday. I will, however, make another careful examination before making up my mind on that point. In the wards I thought I could distinguish a murmur at both apex and base. There was also, a basic systolic murmur, that looks like mitral disease also.

This case presents exactly that form of heart disease in which hypertrophy is most prominent. This hypertrophy is a direct result of the increased action of the heart. In mitral disease there is usually hypertrophy with dilatation.

As regards the cause of the patient's sickness the well authenticated history of numerous attacks of hemiplegia affords us a very valuable clue. The man has had syphilis. As a consequence of that disease there has probably been a gummy tumor thrown out which presses upon the spinal cord. This tumor is probably inside of the spinal membrane. It is located so high up in the cord as to cause paralysis of one of the arms. This same syphilitic disease has no doubt also brought on atheroma of the arteries thus causing vegetations of the valves of the heart.

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Two months ago when the aortic disease was not so prominent I ordered digitalis for the man, but digitalis did him no good, and why, you will ask. Digitalis is indicated in cases where the mitral valves solely involved and where there is decided failure of the heart's action. The treatment was immediately altered and gtt. V. of the tincture of the root of aconite were administered thrice daily. In seventy-two hours there was very marked improvement noticeable in the case, and even since that time the man has been getting gradually better. I never expected him to be so well as he is to-day. The improvement I may say, I think, has been constant.

So soon as the acute cardiac symptoms abated I put the patient on the use of strychnia and stopped the aconite. With regard to the prognosis of heart disease; it is a well established clinical fact that we can never permanently cure valvular disease of the heart, our treatment should therefore be chiefly directed towards the relief of the patient. We do this by unloading the venous congestion and by a well chosen and general tonic treatment. This patient is now well enough to be sent to the paralytic ward where he can wheel himself about with his one remaining unparalyzed member and so break up to some extent the monotony of confinement in bed.

II. MITRAL REGURGITATION.

This woman has been sick since Easter. Her feet and legs are very much swollen. Her hands are not swollen. The dropsy is therefore not universal and so we can at once exclude the idea of kidney disease. She complains of pain in the pit of the stomach and shortness of breath. These symptoms have been constant since the beginning. The stomach is slightly swollen.

Upon percussion I find the upper border of cardiac dulness entirely normal. The right lateral border of dulness is much further to the left of the sternum than is natural. The heart can not therefore be hypertrophied.

Auscultating the chest at the mid-sternum and at the apex, I find a very distinct murmur at both places—intensi fied at the apex. This murmur is not heard at the aortic cartilage nor at the base. So much as concerns the site of the murmur. Now as regards its time. The murmur is evidently systolic, a mitral regurgitant.

This case is a very useful one as illustrating one interesting clinical fact. Do murmurs displace the natural sounds of the heart, or do they not? I never heard both natural sounds and murmurs so distinctly as in this case. I hear here all three sounds—the normal first sound, the mitral murmur and the normal second sound.

This is the most common form of heart disease. The insufficiency of the mitral valve forces the blood back into the left auricle, thence into the lung, thence to the right ventricle, thence into the venous system, and thence into the portal system; so bringing on œdema of the feet, legs, and abdomen.

This case is preeminently one for the use of digitalis. This woman will be given gtt. XV. three or four times daily. How are we to get rid of the dropsy? one of the best means at our command is by the

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use of mercurial purges followed by saline cathartics. In private practice I should order gr. iij. of blue mass every night to be followed by half a tumblerful of Hungadi Janos water in the morning. In place of the mineral water sulphate of magnesia may be given. The cause of the disease is specific in this case also.

ORIGINAL ARTICLES.

INTERVENTION OF PHYSICIANS IN EDUCATION.*

BY
E. SEGUIN, M.D.

MR. PRESIDENT AND CONFRERES: I said to you last year "New social and individual wants demand new solutions of the problem of education; and most of these expected solutions rest with the physician and physiologist." This implies no personal criticism of our teachers, whom we consider superior to any equal number of women and men anywhere. It is simply the re-assertion of a fact concerning the evolution of the idea of education.

According to the object of societies this idea differs. Now that children are sent to school no more by scores, but *en masse*, imperfections have become apparent in the American Public School, which did not appear in our old District School—once a model for less advanced nations. Now it is our turn to reform, if we have the least pretention to keep the leadership. But looking only homeward—as children outgrowing their clothes must be supplied with larger ones—so our next curriculum must be enlarged to meet the demand of the American people for ampler development of their destiny.

In this respect, the managers of our school-system have already erred for not perceiving that the present schooling—superficial in some things, barren in others—has, besides many government-leeches, turned in stores, and out of the farm or skilled manufacture, more ablebodied drones than it is healthy for a nation to feed in girl's occupations. These managers ought to have understood that educating millions is a different affair from polishing a few privileged; no scholastic or Chesterfield's nonsense in the idea of universal education.

But because education was ever before a class monopoly, the present *concept* of "educating in the masses the working aptitudes" had hardly been the object of a thought of the thoughtful. True, Rousseau had declared that each man must have, besides a fair education, a trade, and Prince Albert had given a trade to each of his royal children. But the prince of syllogism and the prince of common sense were not to the liking of the ruling sharpers of their time; so that it is but recently that the idea that "everybody must be educated to produce enough for his own wants and those of a least a wife and child, or of an aged or crippled relative," lighted up our moral atmosphere like a revelation; as came to our forefathers the ideal of equality, of

*Read before the American Medical Association at Buffalo, June, 1878.

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which our present ideal of the duty of labor for all is but a corollary.

This new social element—as indelible as a baptism—must take the child at his entrance in school, carry him through it, and out of it, stronger, healthier and better gifted for the enjoyment of his liberty. That will be the gain of a physiological education; that is what Descartes foresaw when he prophesied that if mankind (as a kind) could be improved, it would be through the progress of medical science. The realization of this prophecy is at hand, since we clearly see the part that the physician will take in their education.

1.—*During Vacation*, the physician in charge must have supervised the school, seen that everything is clean, and uncleanliness almost impossible; that the grounds be drained in the right direction, and shaded on the proper side; that lights be kind to the eye; that the books, charts, images, and the like be duplicated in several types to suit the different conditions of vision; that the desk fit the progressive ages, and the seats the diversity of shape of the children, particularly of the girls—according to the admirable directions and drawings of Liebreich.

2. *Before Entering the School* the pupils must be scrupulously examined, and their status minutely recorded, as much as possible in figures, with the metric system and centigrade thermometers, in regard to:

Their general appearance; condition of skin and glands; relations of age to size; relations of size to weight; relations of proportions of parts, or relations of proportions of head to face; relations of proportions of trunk to limbs; conformation and proportions of head; conformation and proportions of mouth; conformation and proportions of ears; conformation and proportions of eyes; conformation and proportions of hands; irregularities of both sides; spinal anomolies (carefully surveyed); breadth and thickness of the chest; circulation; respiration; temperatures,—central, local, superficial; possible differences on the two sides.

Remarks on the influence which the above conditions must have on the general and special training of the child, what to avoid and what to look for for him in the school.

3. *Before Alloting a Child to a Class-Room*, and in it to one place in relation to the teacher and teaching apparatus, let us consider and note the reach and degree of precision of his sensory organs, and particularly, wherefrom will he see and hear best? Otherwise placed, his senses may grow worse; or the erectile tension of their organs, which causes the attention of the mind, being found useless will slacken, and the desire for learning will die away in proportion to the impairment of the senses, as to the consciousness of the inutility of further efforts. Many educations have failed for this neglect of the physiological conditions of some mode of perception. For the eye let us be guided by the table-tests of accommodation, and for the ear, follow those of Sapolini and Milano.) The defects so stated it is easy to see from time to time if they are growing less or worse.

By hygienic cares and a wise progression of acoustic exercises, the hearing may be improved in the school; but for the eye the school con-

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ditions are almost fatally adverse. Since there is an incessant demand for the eye to look, mainly in a maze of speck-letters, if the eye was healthy at first, from constant reading it may become sick; and if already sick, it will grow worse in a progression which has been calculated, and found commensurate to the duration of the curriculum, and to the intensity of the studies in this wise: "All myopic eyes are diseased," says Donders. In the first year of reading 0.4 of the scholars become myopic; in the second 4.8; in the third 8.6; in the seventh 11.3; in the ninth 24.1; in the eleventh 49.5 and the proportion increases also in proportion of the intensity of the studies; according to authorities too competent to be doubted, too numerous to be named.

Would not it be humane in teachers to acknowledge their incapacity to deal alone with this problem, and to require, instead of shunning a physiological examination which would indicate what types the children must be given to read, and other cares to be taken at school of their sight? Thus only could be stopped the fearful increase of myopism, which seems to tend to make men the rivals of the fishes of the Kentucky Mammouth cave. Some say it matters little as long as we can only buy spectacles. On this score it would be better yet were we born with this astride ornament. But myopia, and other eye affections of school origin, are more than physical disease and infirmity; they create most regretable incapacities, as of exercising many select industries, and most of the fine arts. They have also a decided influence on the mode of formation of judgement, which, in short, or otherwise ill-sighted people is biassed by the necessity of looking at things not as they are, but as they are imagined or liked to be.

Three remedies or prophylactics can be prescribed by the school physician, with the view, if not to cure myopia, at least to stay its progress. One already hinted at is the use of books and other prints, whose types must correspond to the visual accommodation: another the supply of an abundant and unique light (the one coming from the left being preferable); the third to transfer most of the studies, exercises, and amusements in the garden-schools, summer-schools, natural history and drawing excursions, in which the eye is invigorated in distant and placid horizons.

At the same time, the school physician will have discovered other defects of the senses and of the muscular functions. Among them the difference of contractility, therefore of liability of the two hands, native or resulting from the habit of not using the left when the right works or plays. A habit which secures a ticket for later hemiplegia, unless the school-physician makes the children use both hands; and in case the difference is proven extreme or progressive (by dynamometry), he must make the weak side work for two. An every morning medical survey is expected from the school-physician; first as a quarantine measure against the introduction, in the crowd, of children contaminated by zymotic or contagious diseases, the suspected ones to be kept under observation in regard to the pathological temperatures and other signs which precede the specific symptoms by several days; second, as a means of discovering the simulated diseases as well as the

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dissimulated ones (the innocent being so crafty), as in the following case just come to my notice: "A ten-year old school-boy in Holyoke, Mass., refused to do his writing lesson because he could not lift his arm to the desk, and examination proved that his collar-bone was broken. This had happened two days before, and he had performed all his other duties since, sooner than acknowledge the accident, for fear of being punished."

During the session, and particularly at the changes of season and of temperature, it is important to note the effects of the course of studies on the children. Their mind, which was a blank when they entered the class-room, is no sooner set to work at intellectual or mathematical combinations of facts, ideas or figures, than the rhythm and number of the pulsations are changed, the heart beats stronger, the blood flows to the head through the visibly increased calibre of the arteries, the volume of the head is increased too, the general temperature is higher, that of the head considerably so, sometimes that of the one side only or of the base, whilst that of the extremities has cooled. Call it if you please an intellectual perturbation, but its action on the physique cannot be overlooked, since its frequent recurrence every day threatens danger.

In former papers I have quoted the fate of scholars killed by the congestive and combustive processes of thinking. Last fall another was added to the fatal list, the worthy grandson of the physiologist Richerand: and this spring offers in holocaust the poet laureate of Yale College. The New York Female Normal College has its martyrologe too; and I doubt not that our public school has its victims, since I attended quite a number of its children sick from over-work.

5. At this point the physician must interfere in education. Comparing the present condition of the functions to what they were on entering the school he sees what alterations have taken place. If there is any, he must study the differences of pulse respiration, temperature, urea, etc., before and after the morning and evening sessions, and if the differences found justify his interference, he must order the child out; to the garden-school, summer-school, in drawing and natural history excursions, or at least several times a day up to the *solarium* which can easily be arranged on the flattened roof of the school-house.

Reverting from these hygienic and prophylactic duties to more educational ones, the physician will have to create and organize.

6. The physiological training of the senses and of the hand executrix of thoughts; not as a criticism of the intellectual culture but as its complement.

(a)—As early as the primary department, the senses are to be trained to perceive phenomena to the utmost of their natural precision, and the hand to execute the dictates of the will with force or delicacy, altogether with the rapidity of conduction of the nerve-apparels. In this class would be developed the taste of the artist, artisan or cultivator, and formed forever these manual dexterities of the hand: prehension, pression, pressure, tacts, contracts, etc., whose excellence have

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prepared the success of the mighty laborers, Morse, Gavaret, Faraday, and confers the sceptre of surgery.

These natural treasures refound could be bestowed very cheaply among the masses who need them most, and where they would raise enormously, without further expense, the quality, beauty and value of all hand-products.

(b.) But as the child progresses in his intellectual education, the training of his senses and hand must take a more elevated form. After having operated unaided, they have to be taught the modus operandi of the instruments and methods which give a farther reach than nature to their senses, and a more unerring power to the hand executive of the will.

By this double acumination of the senses and of the hand the child has strenghtened his instruction by an almost illimited range of powers to do best what he will like best. Moreover, besides having been taught to perceive the infinite smallness and in magnitude (instead of only reading about it) his philosophy will be proof against the fooleries of the past; and ready to tender to nature the reverence it deserves, he will feel himself like embedded in the constantly enlarging realities and ideals of this world, as in his true Alma Mater University.

7. All the while the school physician continued to keep his record of the vital powers; noted in graphics or in figures their progress, retardation or retrogression, pointing to the causes thereof; so that when the teacher will dismiss the pupil with his certificate of capacity in the branches of learning, the manager of the vital functions will add a summary of his physiological powers of perception, of action and of endurance—which is, after all, the hard-pan of all capacity. In a word, the teacher's certificate will tell what the aspirant to manhood knows, and the physician's what he can.

Make up now the sum of these individual powers and that of the National powers requires only a simple addition. The Nation will feel and know her strength.

If anybody supposes this plan to be Utopian, let him look at its partial realization in an older, but less important branch of the public service. The armies—in other respects barbarous organizations—are fifty years (I hope no more) in advance of the school—an instrument of progress in other than this respect, *i. e.*, the necessity of a more physiological education. In proof of which assertion, two instances forcing themselves here, will detain us but an instant, and I have done.

The expedition of Abyssinia succeeded only because the medical staff of the English army had tested the worth of every man by the method of physical diagnosis, and with the instruments of positive observation, allowing none to join the picked band whose temperature, respiration, two pulses and cardiography had not given normal results. So selected, the valor of these men proved to be equal to their worth; their heroism was natural, and the victor of Magdalla was not Hercules, but Escalapius.

To this achievement of the Anglo-Saxon physician let us add another won by our Army Medical Corps. To Drs. Woodward,

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Billings, Baxter and their associates are due those medical and surgical reports and tables of vital statistics which demonstrate (all previous prejudices notwithstanding) the superiority of size, proportions, weight and endurance in the field and in the hospital of the neo-American.

With a living material more numerous and more sensitive to the changes to be obsevred, when will the American school be able to show something like this last triumph of army medical science? When school physicians will not be confined to look at the privies instead of playing in education a part much more important for society at large than that of the surgeon in the army. This improvement will commence when the Laplaces, Aragos, Cuviers, Humboldts, Virchows and Littres of this country will be the school authorities.

We live in an age in which the old motors have ceased to move; when credoes are replaced by analysis; when the duty of working at his best becomes general; when, in order to work, everybody needs his physiological aptitudes to be trained as productive capacities; when the public and private records of the school will alone furnish the measure of the capacity of each and of all.

Who will take that duty in charge?

It may be considered hard for men who have spent in studies more than a third of their probable career to devote the rest to a part of their profession so little remunerative, and so fraught with enmities. But these considerations—though strongly appealing to egotism—are powerless against the fiat of a ripe idea. The idea of a more physiological education has ripened out of the failure of scholastic and classical education, like a rich kernel bursts in leaves and fruit out of half rotten manure.

The irrepressible want of modern times is that all men be educated; all educated men must work; education must prepare them to work at their natural best; this preparation is obtained best by a physiological training; physicians alone can carry that training and give a scientific authenticity to its record; it must be done, therefore they must do it; because—above other causes—the folly of to-day is the wisdom of to-morrow.

A word more and I close this invitation to physicians to take their natural part in education: Some put the riches of this country in its mines, some in its commerce, some in its manufactures, some in its immeasurable breadstuff, some in its inexhaustible herds, but do not believe them. The true riches of this country—without which all others are like chips in the mouth of the hungry—are our children, if physiologically educated.

If I have imparted to you my conviction, you will name a commission to examine the practicability of the intervention of physicians in education, and to report on the same at your next meeting.

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HOSPITAL RECORDS.

MT. SINAI HOSPITAL, N. Y.

Reported by BENSON W. FELDMAN, M.D., House Surgeon.

EPITHELIOMA OF THE RECTUM, LUMBAR COLOTOMY.—RELIEF.

E. E———. Male, aet. 40. Russia. M. Hatblocker.

Family History.—So far as he knows, there neither is nor has been any cancerous disease in his family.

Past History.—Has always been a perfectly healthy man up to the commencement of his present illness, with the exception of hæmorrhoids, which first appeared about his fourteenth year. From that time until his thirty-first year, they troubled him only about four times ; then appearing externally as small, hard lumps, that, while causing some distress, gave rise to no positive pain, at each of these times there was a little bleeding. His bowels were always regular.

Two months ago he began to suffer intense pain in the rectum ; passed considerable blood before and after stool, and noticed that he was loosing flesh very rapidly. It was at this time also, that he first noticed pus in his evacuations. The pain and tenesmus were so severe and continuous that he lost much sleep at night, and found no position comfortable during the day. Emaciation, increase in pain, and the "bearing down" sensation grew worse daily, and he sought relief in hospital.

On admission, (July 8th, '77), the above mentioned symptoms were noticed. On examination, there was seen a small bluish elevation around the sphincter ani, while about one and a-half inches above the sphincter were found a number of hard, lobulated elevations, especially marked on the anterior wall of the rectum. The urine was examined and found to contain neither albumen nor casts.

Sept. 1st.—During the past two month's there has been no improvement whatever in the patient's condition. Pain and tenesmus still very severe. Temperature always normal. There has been some dysphagia, with enlarged glands under the lower jaw ; this, however, passed off in a few days. The stools have been numerous, liquid and bloody, and contain considerable pus.

Sept. 11th.—On consultation with the medical and surgical gentlemen of the hospital, it was decided by the majority that removal of the rectum was out of the question, as the disease had extended too far up the gut, especially on the anterior surface of the rectum, where it ran up about two and a-half inches. It was thought best to do Amussat's operation for producing an artificial anus.

Oct. 8th, (3 P. M.).—The patient being etherized, Dr. Daniel M. Stimson proceeded to perform the operation of lumbar colotomy.

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Owing to defects in the syringes on hand, the gut was but imperfectly inflated with air. The patient was placed upon his abdomen, somewhat inclined to the right side, a pillow being placed under the left side to render the loin sufficiently tense and prominent. An oblique incision three inches in length was made midway between the crest of the ilium and the line of the ribs; the center of the same being about one inch behind the central point of the crest of the ilium. Two small arteries were ligated. The outer edge of the quadratus lumborum having been reached, it was cut through and a mass of intestine at once showed itself. This proved, however, to be the small, instead of the large gut; the latter not being sufficiently distended to come into view. Owing to this condition, considerable search was necessary to expose the colon. When found and exposed (it being recognized by its longitudinal bands) the necessary sutures were passed through it; it was opened longitudinally, and stitched to the integument about the edges of the incision, room being left for the introduction of two drainage tubes to the very bottom of the wound. The parts were dressed with carbolized oil and cotton.

The patient recovered well from the ether, and at once experienced great relief, the distressing symptoms that had, before the operation, harassed him day and night, having entirely disappeared.

Oct. 11th.—Passed fæces from the lumbar opening. Considerable deep suppuration from the unavoidable handling of the parts in searching for the colon. Primary union took place everywhere except at the points where the drainage tubes were, it, however, healing kindly after their removal. From this on the patient did very nicely.

Jan. 1st, '78.—Discharged improved.

[*June 6th*, '78.—Pain returned in full severity about three months after the operation, as also the tenesmus. For the past month has been unable to sleep much nights, and is in constant pain day and night, unless he has several hypodermics of Magendie's solution of 30 minims each. For some time has had pain in the bladder. Is now obliged to use a catheter. Pain in the bladder more intense after micturition than before. Urine bloody and offensive. Pus and blood from the rectum. He is greatly emaciated. Has cough and purulent expectoration.

On examination the disease of the rectum is found much increased; the hard elevations extending up the gut beyond the reach of the finger.]

NEWS ITEMS AND NOTES.

American Medical Association.—The 29th annual meeting was held at St. James' Hall, Buffalo, on June 4th, 5th and 6th. The association was called to order by the President, Dr. T. G. Richardson of New Orleans, after which prayer was offered by Rev. L. Van Bokkelen, D.D. At the close of the prayer Dr. Thos. F. Rochester of Buffalo, Chairman of the Committee of Arrangements, was introduced and delivered an address of welcome, extending to the members an invitation to visit points of interest

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in the city, and assuring them that all the physicians of Buffalo were most heartily at the service of the association.

The secretary reported 330 delegates as registered, and announced that he had received charges against various medical societies and protests against the acceptance of certain candidates for admission, which, on motion, were referred to the Judicial Council.

President Richardson then addressed the meeting, calling attention to what had been accomplished by the association in elevating the standard of medical education in the United States and urging that the agitation of this all-important subject be continued, as it is only in this way that the current of reformation can be kept in motion. He called attention to the fact that original investigation was very much neglected in this country, and proposed to encourage such researches, that the Federal Congress should be petitioned by the entire profession, to establish means for pursuing investigations in connection with the Army Medical Museum and Library of the General Government, which has, unintentionally no doubt, already founded a school which, through the influences just indicated may possibly be made the nucleus of a great national institute, in which original research in all the sciences upon which medicine more immediately draws shall be conducted, with the same wisdom and efficiency as characterize its present management. Another plan to encourage investigation the President suggested would be for the association to offer four annual prizes of not less than two hundred and fifty dollars each, to be awarded at the close of the second year after announcement, for strictly original contributions to medical and surgical progress.

The important subject of State Medicine was next considered. State Boards of Health had been established in the following states:

Alabama	1875	Massachusetts	1869
California	1870	Michigan	1873
Colorado	1876	Minnesota	1872
Connecticut	1876	Mississippi	1877
Dist. of Columbia	1871	New Jersey	1877
Kansas	1875	North Carolina	1877
Illinois	1877	Tennessee	1877
Kentucky	1878	Rhode Island	1878
Louisiana	1870	Virginia	1871
Maryland	1874	Wisconsin	1876

Education of the people in the laws of hygiene was urged as the best means of securing efficient legislation in regard to these matters; and also the establishment of a National Council of Health, composed of members from every state in the Union, who shall cöoperate with and assist a sanitary department which should be established by the general government.

SECOND DAY.

Prof. Henry Smith, Chairman of the section of Surgery and Anatomy, then delivered his address, taking for his subject: "Certain points on the Pathology of the Bones, especially Tubercle." After alluding to the opinion of former years that the skeleton was

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intended to support the body, he mentioned that recently a new function had been assigned it, the bones being now regarded by many as a "focus for the origin of the white and red corpuscles of the blood and through which serious diseased matter was introduced into the general circulation."

After showing its connection with septicaemia and blood poison, he discussed the original progress of tubercles in the bones, and their influence on Pott's and hip disease, both of which he thought were of tubercular origin.

The address was a very able one, and occupied the closest attention of the Association for nearly an hour. It was referred to the Publication Committee.

Dr. Frank H. Hamilton of New York, by request, next presented the essential features of the able paper prepared by Dr. E. Seguin, of New York, on "The Intervention of Physicians in Education," read by the author before the Section on State Medicine and Public Hygiene the previous afternoon. He stated in explanation that it was owing to Dr. Seguin's inability to speak fluently the English language that he appeared in his stead.

On motion of Dr. Toner the paper of Dr. Seguin was referred back to the section for publication.

When Dr. Hamilton had concluded the reading of extracts from the paper he said that it was hoped that the paper would be well discussed. Accordingly he spoke at some length upon the subject matter, dealing principally with the hygienic affairs in New York, and emphatically endorsed the paper. His remarks were interspersed with characteristic witticisms and the whole was listened to with marked attention, the applause at the close denoting the approbation of the Association.

Owing to the lateness of the hour, further discussion, the President announced, was unavoidably prevented. Dr. Hamilton, therefore offered the following resolution, which was unanimously adopted:

Resolved, That in the opinion of this Association medical men ought to have a voice in the construction and location of public school buildings; in the question as to the age at which children should be admitted, the hours of study, and the general management of these institutions; and to this end it is believed to be necessary that one or more intelligent physicians should be placed upon Boards of Education, Boards of Trustees, and upon other similar boards having the control of public education and schools.

The usual ten minutes recess was now taken to select the committees on nominations.

THIRD DAY.

Dr. A. L. Loomis of New York, Chairman of the section on Practical Medicine, Materia Medica and Physiology, was then introduced and delivered an able, exhaustive and interesting address. He noticed some of the important advances made in Practical Medicine, Physiology, and Materia Medica, and also discussed at length the climatic treatment of pulmonary phthisis. His address concluded with the following practical suggestions:

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It seems to me that the necessities of our time are demanding the establishment not only of well organized and thoroughly equipped sanatariums by the sea, in the mountains, in the cold regions of the North, and in the warm regions of the South, but that our mineral springs should be utilized for the care of disease. No one doubts but they are equal if not superior to those of the old world, yet to-day we know more of the virtues of Karlsbad, Kissengen, Vichy, and Hunyadi waters, than those of Saratoga, Virginia, Arkansas, and Colorado. Has not the time come, gentleman, when some organized action should be taken in this matter?

REPORT OF THE COMMITTEE ON NOMINATIONS.

After due consideration the Committee on Nominations respectfully report that they have nominated the following gentlemen for the various offices named, to wit:

President—Theophilus Parvin, M. D., of Indiana.

Vice-Presidents—A. J. Fuller, M. D., of Maine; W. F. Westmoreland, M. D., of Georgia; John Morris, M. D., of Maryland; John H. Murphy, M. D., of Minnesota.

Treasurer—Richard Dunglison, M. D., of Pennsylvania.

Librarian—Wm. Lee, M. D., of District of Columbia.

Committee on Library—John Eliot, M. D., of District of Columbia.

Next place of meeting—Atlanta, Georgia.

Time of meeting—The first Tuesday in May, 1879.

Assistant Secretary—Scott Todd, M. D., of Atlanta, Ga.

Committee of Arrangements—J. P. Logan, Chairman; H. V. M. Miller, G. G. Crawford, H. L. Wilson, J. F. Alexander, J. M. Johnson, Charles Pinckney, V. H. Taliafierro, J. T. Johnson, of Atlanta, Ga.

Committee on Prize Essays—Robert Battey, of Rome, Ga.; J. G. Westmoreland, of Atlanta, Ga.; Wm. A. Love, of Atlanta, Ga., Robert Kidley, of Atlanta, Ga.; Henry F. Campbell, of Augusta, Ga.; J. H. Van Deman, of Chattanooga, Tenn.

Committee on Publication—Dr. Wm. B. Atkinson, Chairman; T. M. Drysdale, M. D., A. Fricke, M. D., S. D. Gross, M. D., C. Wistar, M. D: R. J. Dunglison, M. D., of Pennsylvania, and Wm. Lee, M. D., of District of Columbia.

The committee also report the following nominations for Chairmen and Secretaries of Sections for 1879.

I. Practice of Medicine, Materia Medica and Phyisology—Dr. Thomas F. Rochester, of Buffalo, N. Y., Chairman; W. C. Glasgow, of St. Louis, Mo., Secretary.

II. Obstetrics and Diseases of Women and Children—E. S. Lewis, of New Orleans, Chairman; J. R. Chadwick, of Boston, Mass., Secretary.

III. Surgery and Anatomy.—Moses Gunn, M. D., of Illinois, Chairman; Dr. J. R. Weist, of Indiana, Secretary.

IV. Medical Jurisprudence, Chemistry and Psychology.—Dr. Wm. M. Compton, of Mississippi, Chairman; L. M. Eastman, of Maryland, Secretary.

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V. State Medicine and Public Hygiene.—Dr. John S. Billings, of District of Columbia, Chairman; Dr. J. T. Reeve of Wisconsin, Secretary.

Next week we shall give an account of the proceedings in the several sections. Many of the papers presented we shall publish in full, beginning in the present number with the able address of Dr. Seguin.

Convention of American Medical Editors.—The 10th annual convention was held at Buffalo on the evening of June 3rd, and after listening to a paper on "Abstract of the law of New York State in regard to the commitment of the insane to asylums, their detention and discharge, compared with the statutory provisions of England," by Dr. John P. Gray, adjourned; having elected the following officers:—President, Dr. William Brodie, Detroit; Vice-President, Dr. J. A. Miner, Buffalo; Secretary, F. H. Davis, Chicago.

Association of American Medical Colleges.—This association met at the Buffalo Medical College on June 3rd, the President Dr. J. B. Biddle, in the chair. After receiving the credentials of members, the matter of admitting the Howard University, D. C., to the association was taken up. Objections to doing so were raised, and after some discussion, sustained; and the college refused admission by a vote of 12 to 2.

The Secretary presented a report, from which it is learned that there are twenty-five regular members and one affiliated member. Applications for membership had been received from the Ohio Medical College March 26th, and the Alabama Medical College March 18th last. As soon as the report was issued last Fall a letter was sent to all regular Medical Colleges of the United States, asking if they conformed to the articles of confederation required of regular or affiliated members. Accompanying this letter was sent the pamphlet containing a history of the organization of the Association, its constitution, by-laws, articles of confederation, and list of members. Two Colleges—Harvard and the Medical Department of the University of Pennsylvania—replied that they regarded it unadvisable for them to join the Association.

On motion, Profs. Davis, Flint and Gross were appointed by the Chair a Committee to consider the whole matter in relation to the classification of the Medical Colleges.

Prof. Gross offered a series of preambles and resolutions contemplating a meeting in September of representatives at Washington, for the purpose of raising the uniform standard of medical education.

Prof. Davis seconded the resolutions. He referred to the efforts made to improve college intsruction during the past twenty-five years, and thought the sentiment had reached a point which demanded an advancement in medical education. He favored a three years' course of instruction, of not less than eight months duration per year, and no student could enter upon his studies in any college until he had first given some evidence of preparation. He hoped to live to see the medical profession at the head of all science, where it belonged, and the adoption of the resolutions would be an important step in the right direction.

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Prof. Gunn, of Rush College, was in favor of a three years' course as to the requisite graduation of students.

The Secretary read a letter from Prof. Seely, of the Ohio Medical College, in which he spoke in favor of a full course. The Secretary also stated that he was of the opinion from the correspondence he had that a majority of the colleges were in favor of a full course.

Prof. Bodine, spoke in favor of the three years course, but thought the time was not suitable. He offered an amendment to the effect that the conference be held under the auspices of the Association, which was lost. The Friday preceding the meeting of the American Medical Association next year was fixed as the day for holding of the Conference, and the preambles and resolutions were adopted.

Prof. Flint offered a preamble and resolution to the effect that the tickets and diplomas of the Nashville Medical College shall not be recognized by the Association so long as the institution gives two graduating courses a year, and accepts three years' practice in lieu of a course of lectures.

Prof. Scott, of Wooster, made some explanatory remarks in relation to the conferring of the honorary degree in the case of a person twenty-eight years of age, and it was decided by a vote of the Association to let the matter drop.

ELECTION OF OFFICERS.

The following named officers were elected for the ensuing year:
President—Prof. J. S. Biddle.
Vice-President—Prof. N. S. Davis.
Secretary aud Treasurer—Prof. L. Connor.

Laryngological Association.—A large number of throat specialists met at the Tifft House, Buffalo, on June 3rd, for the purpose of forming a national association to have annual meetings in various parts of the country. Dr. F. H. Davis, of Chicago, acted as chairman, and Dr. Geo. M. Lefferts of New York as Secretary. After the purpose of the meeting had been stated by these gentlemen a permanent organization was formed and a constitution and by-laws were framed. Drs. Rumbold of St. Louis, Hartman of Baltimore, and Elsberg of New York, were appointed a committee to nominate officers for the following year, and the meeting adjourned until 2.30 o'clock. In the afternoon the following officers were elected:

President—Dr. Louis Elsberg, New York.
Vice-President—Dr. F. H. Davis, Chicago.
Secretary and Treasurer—Dr. Geo. M. Lefferts, New York.
Council—Dr. Clinton Wagner, New York; William C. Glasgow, St. Louis; E. L. Shurley, Detroit; J. H. Hartman, Baltimore.

The name fixed upon was the National Laryngological Association. The first annual meeting will be held in New York the second Tuesday in June, 1879.

Personals.—Dr. Harrison Allen, of Philadelphia, has been elected to the chair of Institutes of Medicine, in the University of Pennsylvania, succeeding the late Prof. Francis Gurney Smith.

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—Dr. Wm. F. Lockwood, Jr., has been appointed Associate Demonstrator of Anatomy, at the College of Physicians and Surgeons, Baltimore.

A Visit to the Women's Hospital.—On the kind invitation of Dr. Bozeman, Attending Surgeon to the "Women's Hospital," we last week had the pleasure of visiting that institution and witnessing his peculiar methods of treatment. The doctor first showed a case of vesico-vaginal fistula in which the whole upper surface of the partition was absent, with numerous bands of hard cicatricial tissue that kept the edges widely asunder, in fact a most aggravated case, and one which, without the aid of his speculum and table, would be considered incurable. Before final operation three or four weeks of preparatory treatment were found necessary. This treatment consisted in cutting across the bands of cicatricial material and then inserting a vaginal plug. By this means the tissue is rendered less rigid, and after a time the two edges can be drawn together so as to meet accurately without very much force of traction. As soon as this can be done, the case is ready for operation. In this instance the doctor fully demonstrated the value of his instrument and it is very difficult to understand why it is not more generally adopted by the profession. It posesses all the advantages of Sim's speculum, has none of the disadvantages that pertain to that instrument, and may be used with the patient placed in any conceivable position. One very valuable feature of the instrument is that it is self-retaining, and the physician using it every day in his office requires no constant assistant. It also serves as an excellent rectal speculum, indeed there is no better, as was demonstrated in the case next shown by the doctor, in which he ligated four internal hæmorrhoids with its aid.

The remainder of the afternoon was occupied in the treatment of cases of flexures and displacements, which Dr. Bozeman considers in most cases to be due to want of proper vaginal support. His method of treating these diseases, consists in first making the uterus freely movable by carefully introduced vaginal tampons, so placed so as to force the uterus into its correct position, and then the insertion of his vaginal supporter, an instrument ingeniously constructed to answer all the purposes of the multitude of pessaries now in use, but entirely devoid of all their deficiences. The same instrument answers all the indications, either of backward or forward displacement, and may be used indifferently with equal efficiency in either. It cannot cause ulceration in any part of the vagina, is easily adaptable and can be introduced and withdrawn by the patient herself. The doctor claims more success in treatment by its means than with any instrument yet devised, and we have no doubt but that its introduction into general use will mark a new era in gynecological practice.

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THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY.

A WEEKLY JOURNAL OF MEDICINE, SURGERY AND THE COLLATERAL SCIENCES.

EDITED BY

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EDITORIAL.

DRAM SHOPS.

No one will deny that the question of liquor selling is a proper theme for discussion in a medical journal. We do not propose, however, at this moment to discuss the matter in either a medical or scientific point of view, but only to call attention to its relations to medicine, to hygiene, and to the interest of our craft, generally, and to invite the profession to its wider discussion. The recent efforts of the Rev. Dr. Crosby, and of the "Society for the Prevention of Crime," of which he is the President, to close the 10 or 12,000 liquor saloons of this city, and thus deprive a million of people of the free and unrestrained use of stimulating drinks, has suggested the following brief remarks:

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If Dr. Crosby and the society which he represents, aided by the "Apostle" Mundy, succeed, the chief source of crime and pauperism in this city will be cut off; the springs will be dried up,and the great streams which now flow toward the hospitals, the morgue, the alms houses and the penitentiaries will cease, or become mere rivulets; our enormous taxes will be greatly reduced, rents will fall, capital will seek investment and labor will be in demand.

But these are matters for the statesmen to consider, rather than for us; or at least we may say, our interest in these matters is only incidental as citizens.

It is our special duty, however, to consider the vast amount of sickness which is directly and indirectly traceable to this cause. From every liquor saloon in this city there comes daily a procession of men, women and boys, who have unsuspectingly been poisoned by the seductive dram, marching with halting and irregular steps, their garments torn and soiled, their eyes bleared, their noses red, their intellect stupified, dyspeptic, neuralgic, rheumatic; trembling, wheezing, coughing; suffering from hepatic diseases, renal diseases, chronic ulcers on the legs, vomiting and breathing out foul odors. A part of this procession finds its way with difficulty to those places these lepers call their "homes",—to their wives and children; but a greater part find their way more easily to the station houses, the prisons, the hospitals and the morgue.

These people have taken for months and years a subtle poison, and their infirmities are due solely to this cause. In whatever form administered, it is still the same poison which has produced these varied results It is alcohol. Tobacco may have had its share in supplying the rank and file of this procession, but alcohol is the most active recruiting officer and drill-master.

Our profession and medical science generally, has another interest in this matter, and one of which we hesitate to speak, because in this case our interest is greatly in the continuance of the free sale of liquors. If Dr. Crosby succeeds,—as it now seems that he will, since Recorder Hackett has put his shoulder to the wheel, if he shuts up the dram shops, there will be a sad diminution of the supply of accidents and of diseases in the hospitals for clinical instruction, and of "material" for dissection. Indeed we do not believe there would be one hospital patient in the free hospitals where there are now ten, or that there would be one subject for dissection, "unclaimed" where there are now twenty; we are not certain that there would be any. What in that event would our 5 or 6 medical colleges do? This is a serious question, and it might be well for the colleges and our profession to find an answer before the shops are shut up and the evil consummated,

Dr. Crosby, Recorder Hackett and the Apostle Mundy, will be held responsible if these results come of their labors and their enforcement of laws. They will be regarded as men who obstruct the progress of science. No more unclaimed dead bodies, and no more "cases of interest" for the medical students who gather annually in this great metropolis, where crime and disease have hitherto been fed and

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nourished, and, when fully matured, have been shut up and exhibited for the instruction and entertainment of men of science

Our readers will pardon us for having fallen into a line of reflection so unpleasant; but that the sources of supply will fail to our colleges if the dram shops are closed, is as certain as that the sun will rise to-morrow, and we are not likely to remain in doubt as to who did this thing.

LECTURES.

CHOREA ASSOCIATED WITH HERPES ZOSTER.

A Clinical Lecture delivered at the Jefferson Medical College Hospital, Philadelphia.

BY

JOHN B. ROBERTS, M.D.

Physician to the Hospital.

[Reported for THE HOSPITAL GAZETTE.]

This morning I have to show you a case which is interesting on account of there being an association between two very dissimilar diseases, and which yet have a common factor since they are both considered to be neuroses. This little girl, aged 6 years, has, as can be seen by the movements of her hands and arms, the disease denominated chorea. The interest of the case, however, centers in the history of the antecedents of the present ailment, which can best be studied by interrogating the parents. The account obtained may be condensed as follows: The child about one year ago had measles and has been rather delicate ever since, but has never had rheumatism. The parents have never suffered from rheumatism they say, though both mother and father are subject to vague pains which their physician denominates neuralgia. Three weeks or so ago there appeared an eruption on the right chest of the girl which was characterized by vesicles extending in groups around the body.

It was situated over the scapular and the pectoral regions. This the attending physician told them was shingles, and he was certainly correct, for we can see now the dried vesicles and the superficial cicatrices still existing in the localities mentioned. One week after, symptoms of irregular muscular twitching of the hands were observed, and this condition is the one for which the child was brought to us for treatment—examination shows slight choreic movements of the hands and arms, the child has a clean tongue, has regular bowels, and presents the marks of recent herpes in the situation referred to. The skin, however, is hot, and as fever is not a symptom of chorea it becomes necessary to examine the internal organs to determine the cause of the elavation of temperature. This might be the result of the constitutional irritation of the inflammatory eruption, if the cutaneous affection were now in its active stage, but there remains only dried crusts, and the acute symptoms have disappeared. Hence the lungs

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and heart are examined, but without any lesion being found. You must in this connection remember that it is not unusual to find endocardial murmurs in cases of chorea, produced by roughening of valves or perhaps by an irregular choreic contraction of the papillary muscles of the heart interfering with perfect valve action. Here the heart is acting rapidly, but no murmur is detected, though the determination of this point is difficult because of the impossibility of keeping the child perfectly at rest. In this, as indeed in all cases, the clinical history is incomplete until we have examined the urine, which shall be done at an early date. You have now an account of the development of this case of chorea, in which there appeared herpes zoster of the pectoral and scapular regions about one week before chorea was observed.

In connection with this patient I shall mention a similar case which, curiously enough, I was shown by my friend Dr. T. D. Ingram, only the day before this little girl was brought to the hospital, and which greatly excited my interest. A boy of 11 years was observed to be slightly choreic last September, but his mother paid no attention to the matter because the symptoms were insignificant. In November, he was seized with articular rheumatism of moderate severity, characterized by pain and swelling in the knees, ankles and perhaps other joints. His brother has also suffered from rheumatic fever, hence there is probably a family predisposition. No medical attendance was obtained for the rheumatic trouble, but some three weeks subsequently Dr. Ingram saw him and found a harsh systolic apex murmur over the heart. A week later choreic movements of a mild character were noticed in the right hand and muscles of the face. These increased until soon there was such marked chorea affecting the face and extremities that the patient was unable to sit in a chair, but kicked and threw his arms about with great violence and made continual grimaces. The right arm and leg became partially paralyzed so that he dragged his foot when he attempted to walk and had a very feeble grasp. At night he was very restless, but when he fell asleep the irregular movements ceased. He was treated with alkalies, digitalis, bromide of iron, arsenic and antispasmodics according to indications. When he began to lose flesh rapidly, and showed signs of exhaustion the doctor prescribed stimulus and cod-liver oil. The greatest relief, however, as to the chorea seemed to be obtained by hypodermics of a $\frac{1}{60}$ of a grain of atropia, which were administered twice at an interval of four days. He had been taking also belladonna internally and Fowler's solution without much apparent benefit. On the third day after the first subcutaneous injection, which was given by the right arm, he complained of burning pain and says there were red places on his right arm. This was about nine weeks from the time Dr. Ingram had first seen the choreic movements in the right hand and face. The motor palsy was practically well at the time the eruption appeared, and the chorea had improved. When I saw the patient there were a large number of flat vesicles coltected in groups over the great pectoral muscle of the right side, beginning near the middle of the sternum; similar groups were scattered down the inside of the arm nearly to the elbow, and again over the scapula below its spine. These vesicles contained a yellowish

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and opaque fluid, which was evidently purulent, but there seemed to be no tendency to pointing or spontaneous rupture. In addition, the lower part of the arm and upper part of the forearm presented diffused redness in large irregular patches which had distinctly defined margins as though there was some infiltration under the skin. At one point I noticed a small isolated spot which presented the appearance of urticaria. It was difficult to determine in this case the cause of the eruption. That the vesicular eruption was herpes zoster there is not the least doubt, but whether the other portion of the eruption was produced by the atropia or arsenic it is difficult to say. Belladonna does produce a cutaneous affection at times, but it is rare to find a vesicular eruption resulting from belladonna, though it is stated that this does occur. It is hard to believe, moreover, that an herpetic eruption from this cause would follow the track of the intercostal and internal cutaneous nerves of the arm. I must mention in addition, that this poor little patient has also disease of the kidney, as shown by the presence of albuminuria and casts.

In the child before you then, gentlemen, and in the case related we have two interesting affections combined. In the first, herpes zoster of the right side preceded the chorea by one week ; in the other, there existed chorea for many weeks before the eruption was developed. While giving you the history of these cases I have incidentally mentioned the characteristics of chorea ; but it may be well to review a little more logically. The movements which you see are almost pathognomonic and consist of involuntary convulsive twitchings, often more marked when the patient makes any effort to grasp an object or to walk. They usually subside during sleep. The disease usually, though not necessarily, occurs in childhood, and eventuates in most instances in a cure. It must be recollected, however, that death may occur from exhaustion when the disease is acute and the movements incessant. I had charge of such a patient once whom I was obliged to tie in bed on account of the violence of the convulsive motions which threw him out upon the floor. Death occurred in this case suddenly. In regard to the pathology of the disease we are much in the dark. There is often an evident rheumatic history of the patient or his family and frequently, as indeed happened in the fatal case mentioned, valvular lesions are found. Some writers believe chorea to be due to embolisms in the vicinity of the corpus striatum, and rheumatic endocarditis may be the cause of the embolic plugging. The boy mentioned is interesting in this connection. He had a distinct attack of articular rheumatism and has mitral regurgitation and chorea ; though the chorea was noticed for the first time, it will be remembered, before the rheumatism. This perhaps may point to the fact that the two diseases depend on a similar abnormal condition of the blood and he may have had the valve trouble long before. Partial hemiplegia, as in this same case, is not an uncommon attendant of chorea.

So much for this little girl's chorea, which is, fortunately, not at all severe. I must next tell you something of the nature of shingles or herpes zoster. This is a vesicular eruption which for some reason occurs along the course of cutaneous nerves. In this case it is in the inter-

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costal region, but I have seen it on the buttock, and on the forehead. In fact, I remember well a case where the distribution of the supraorbital nerve was well outlined by the vesicles, which extended just to the middle line. There is generally burning or neuralgic pain before the eruption appears; this may be very slight and may or may not subside with the exhibition of the vesicles. The cause of the disease lies in the condition of the nerves or nerve centers which have in some instances been found to have undergone pathological alterations. Is there any connection between the chorea in these two cases and the herpes zoster? That is a difficult point to decide, since we know so little of the pathology of these two neuroses and I do not know that any cases like these have been reported. Some authorities believe that the lesion of chorea is situated in the spinal ganglia, and some of the well known dermatologists, on the other hand, hold that there is a pathological alteration in the spinal ganglia connected with the nervous trunks with which zoster is connected. If there be any truth in these opinions it is not hard to conceive that a condition of a ganglion giving rise to chorea might set up a change in a neighboring centre that would produce herpes zoster; and so, on the contrary, zoster might be the cause of the development of chorea. This would seem to be even more probable if the two diseases occurred or were most marked on the same side of the body.

What then in regard to treatment of our little patient? For the herpes nothing shall be prescribed, because it is three weeks since it first appeared and the vesicles have dried up and no inflammatory symptoms remain. These scabs will soon be rubbed off and nothing but the superficial scars will be seen. Many drugs have been used in the treatment of chorea, of which the most valuable are arsenic, cimicifuga, bromide of iron, and belladonna. In addition to these you must use chloral and bromide of potassium freely, to give rest to the child if the chorea is violent and thus lessen the danger of death form exhaustion. Here the symptoms are mild, and the child has been in rather bad health, hence I shall continue the cod-liver oil prescribed by the assistants when she first came to the hosptial, and give in addition two drops of the solution of arsenite of potassium after meals. Remember, however, that we shall make further examinations of the lungs and of the kidneys, that nothing may escape us.

ORIGINAL ARTICLES.

JABORANDI AND ITS ACTIVE PRINCIPLE PILOCARPINE.

BY

PAUL H. KRETZSCHMAR, M. D., of Brooklyn, N. Y.

Jaborandi has been used in this country and in Europe during the last four years to a considerable extent for its diaphoretic and sialogogue effects. But, remarkable enough, while the preparations used have given entire satisfaction in the hands of many, severe complaints about the uncertainty of their action can be heard from others.

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Can the difference in the action of— in my opinion—so valuable a drug be satisfactorily explained?

In Brazil where jaborandi has been used as a diaphoretic and—according to trustworthy reports—as a diuretic long before we knew anything about it, the leaves of the following plants are known as "Jaborandi:"—*piper jaborandi* (Willdenon) *Serronia jaborandi* (Guillenica) *Monniera trifolia* (Aublet) and *Pilocarpus pinnatus.*

Who would expect to find that these different plants, which not even belong all to the same species, possess exactly the same properties?

I have used the *leaves of Pilocarpus pinnatus*, the *fluid extract* made of them and last, but not least, the active principle *Pilocarpine* in its combination with hydrochloric acid, known as hydrochlorate or *muriate of pilocarpine.* I have found the action of jaborandi and its preparations in a great majority of cases, *reliable, quick and decided*, and I do not hesitate to say that I consider jaborandi—derived from pilocarpus pinnatus—*as the most powerful diaphoretic and sialogogue* known at the present time. That unpleasant disturbances, such as vomiting, headache, dizziness, fainting, colic, etc., are occasionally found to be produced by it, *might* be expected from such an active remedy, but, aside from slight gastric disturbances, *I have never* found any unpleasant symptoms to occur.

If I employ *the leaves.* I do it in the form of an infusion, which is prepared in the following way. Half an ounce of the leaves is coarsely powdered, and ten or twelve ounces of boiling water is poured over it. The infusion is kept at a temperature somewhat below the boiling point for about 15 minutes and strained. Of this I administer a small teacupful (warm) every two hours, and in the majority of cases I obtained good diaphoresis about 10 minutes after the administration of the first dose. Of the different preparations of jaborandi which I have employed I obtained, generally speaking, the least satisfaction with the infusion. Nausea, vomiting, and sometimes headache accompanied or followed in some cases the diaphoresis produced by the administration of the infusion of jaborandi.

The *fluid extract* which has probably been most frequently employed, has given entire satisfaction in all cases of adults. I employ the following simple formula:

℞

Ext. jaborandi fl (pilocarpus pinnatus)
Syr. simplic, aa ℥ ss.

M.S. Teaspoonful at 2, 4, 6, and 8 P.M., and at 8 and 10 A.M., 12, and 2 P.M. the next day.

The patient is to be kept in bed, well covered, and from 8 to 10 minutes after the administration of the first dose, its diaphoretic action takes place. After the second, and third dose, the diaphoresis is at its height. The flow of saliva commences according to my observations always *after* the diaphoretic action has begun, although it has been stated by others that the sialogogue influence of the drug becomes apparent *before* its diaphoretic action can be observed.

I advise the patient to be careful not to swallow the saliva, but *to*

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let it run from the mouth, and found with this little precaution that vomiting does not generally occur, if at all, it takes place with the 4th, and 6th or 7th dose. Other disturbances I have not observed.

Hydrochlorate of Pilocarpine, derived from the alkaloid found by E. Hardy in the leaves and in the root of pilocarpus pinnatus, is in many respects the most valuable of the preparations of jaborandi. It comes in small white crystals, very soluble in water and is for different reasons especially adapted for *hypodermic* medication. Its action resembles that of the drug itself, but it is *more uniform* and reliable than either the infusion or the fluid extract. It also influences the bronchial secretions by making them more fluid, and it has been used with advantage in croup, bronchitis, etc. A solution is made by dissolving ½ grain of hydrochlorate of pilocarpine in 30 minims of pure water. I use in cases of children from 6 to 10 years of age, 10 mins. of this solution, 1 1-6 gr. hypodermically and repeat the injection once or twice the next or following day. To adults I have given 20 mins. (⅓ gr.) repeated every day for three days.

The simplicity and almost painless manner of its administration, the fact that its hypodermical use does not cause any irritation, or abscess at the point of injection, the easy manner by which we are able to administer it in a state of uræmia, unconsciousness, during convulsions, etc., make it a most valuable remedy in the treatment of children. I used it in five cases of parenchymatus nephritis following scarlet fever, four of which occurred in children under 12 years of age and I can only state that its action was very satisfactorily, although it produced considerable vomiting in one and moderate emesis in another case.

Jaborandi deserves further trial and will be found of good service, when properly used, in cases of parenchymatus nephritis, general anasarca, pleurisy, bronchitis, etc. Prof. Marmé, Gottingen, states: atropine, in small doses, arrests all action of jaborandi, while large doses of pilocarpine *cannot* overcome active doses of atropine.

HOSPITAL RECORDS.

PRESBYTERIAN HOSPITAL, NEW YORK.

REPORTED BY ALBERTO LACAYO, M.D. HOUSE SURGEON.

STRICTURE URETHRAE—FISTULA—EXTERNAL URETHROTOMY—CURE. SERVICE OF DR. DANIEL M. STIMSON.

Bradford Brown—Widower—Aet. 50, Connecticut—Boatman—Admitted April 9th '74.

Previous History.—About thirty years ago, had gonorrhœa. About two years after that he noticed that the stream of urine began to diminish in volume and force. On urinating he had pain in the glans penis and at a point about four inches posterior to the meatus. Some six years ago he says that he had erysipelas (?) of the scrotum into which an incision was made leaving a fistulous opening through

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which urine passed occasionally. Before this occurred he was treated by a physician in his village who, every few days passed a No. 8 English bougie, (but slightly flexible,) into the urethra. The bladder was seldom, if ever entered, though at each sitting considerable blood was lost. The patient states that fainting during these rough probings was a common occurrence, the pain being so severe, and that any one could have tracked him home from the doctor's office by the blood that dripped from the penis. On one occasion he had to stop on the way home and apply a handful of snow in order to check the hæmorrhage. The physician, he says, used to encourage him by stating at every few sittings, that though the bladder had not been reached, he had succeeded in forcing the instrument in another inch.

At one time, no water passed from the fistula for six months. About four years ago external urethrotomy was performed. No instrument was passed after the operation. Occasionally urine has forced its way through the imperfectly united edges of the incision. For the past two years he has been troubled with frequent micturition, accompanied by scalding pain in the urethra. The urine did not all pass away during micturition, there being some dribbling for a little time afterwards. Never had incontinence of urine or retention. This winter (in December or January) a fistulous opening appeared in the left side of the scrotum, but closed in a week's time.

Present Condition.—The patient, though having a good appetite and good digestive power, is in a bad general condition, being pale, anæmic and sallow. Bowels regular. Frequent micturition with some scalding pain during the act. The urine is highly albuminous and contains granular and hyaline casts. A fistulous opening is found a little to the right of the median raphé, while an indurated mass fills the perineum and involves the whole of the posterior part of the scrotum.

April 10th.—Dr. D. M. Stimson examined the patient and found a constricted meatus and a stricture about four inches behind it. No instrument could be passed into the bladder. After the examination the patient was ordered

℞

Potass. bromid.,	gr. xx
Tr. hyoscyami,	m. xv

every two hours, at night, until sleep was induced; as also to rest quietly in bed and drink flax-seed tea.

April 11th.—The patient passed a quiet night. Neither chill nor soreness followed the examination. Ord. diluent drinks. Has some eczema of the thighs from irritation by the urine. Ordered the parts dusted with bismuth, sub. carb., and suspension of the scrotum.

April 14th.—An abscess made its apprearance at the lower part of the scrotum near the raphé.

April 15th.—Abscess opened, evacuated and poultices applied.

April 21st.—Dr. Stimson succeeded in entering the bladder with a filiform bougie. After its withdrawal the patient succeeded in passing a fair sized stream of water.

Operation.—The patient being etherized, Dr. D. M. Stimson pro-

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ceeded to do an external urethrotomy. It was first attempted to pass a small silver staff (about the size of a director) into the bladder. This being impossible, a filiform bougie was, after much difficulty, introduced into the bladder; the silver staff being then passed to the scrotal portion of the urethra.

An incision three inches in length was made in the median ine of the perineum, and the indurated and cicatricial tissues gradually opened from ½ to ¾ of an inch. As the bougie could not be found it was necessary to extend the incision upwards so as to reach the metallic instrument. The urethra being laid open at this point, two loops of thread were passed through the urethral edges which could thus be separated, while the tissues on either side of the filiform bougie were dissected with a fine probe-pointed canaliculus bistoury, and the canal opened for from two to two and a half inches. The meatus was them divided to its fullest extent with Civiale's urethrotome. Otis's dilating urethrotome was then used, and the whole canal cut so as to admit an Otis's No. 40 (F) bulbous sound. The patient made a good recovery from the ether.

April 22d.—Had a chill this A. M. Urine has a *smoky* tint due to thorough admixture of blood. Blood casts found in the urine. Feels sick at his stomach. The urine comes freely from the perineal wound. Ord. Sp't's Vini, Gallici, 3 j q. ½ hor. As this nauseated him and caused vomiting, he was put on milk and lime-water, and beef tea.

Apirl 23d and 25th.—In the morning of each of these days the patient had a child. All the urine passes from the perineal wound. It is scanty, albuminous and contains casts. Anorexia.

April 26th.—Passed a No. 38 (French) gum elastic catheter down to the perineal wound.

April 27th.—Was nauseated and vomited nearly all night. Also had chilly sensations. This A. M. he retains neither food nor medicines. Applied Cantharides blister to stomach, but without relieving symptoms. Tried nitric acid with as little success, and the fly blister was again tried, this time giving relief. The abraded surface was sprinkled with gr's. v of quiniæ sulphat.

April 28th.—Skin dry and cool. Tongue and whole mouth so dry as to render speech difficult. Bowels confined. Has passed no urine for twenty hours. Pulse thready and frequent. Temp. below 97° F. Vomiting continues unabated.

Ord.

Calomel,	grs. xx
Ol. Tiglii,	gtt. ½

April 29th.—Bowels moved freely, (the patient passing the characteristic black fæces of calomel,) and the urine which is about normal in amount, passes freely from the perineal wound, without pain. Tongue moist. Skin natural Has ceased vomiting.

May 1st.—Stomach quite easy. Urine still passes through cut. A No. 18 (English) steel sound passed easily into the urethra as far as the membranous portion where it met with an obstruction. Leaving the instrument in the urethra, a No. 23 (French) flexible bougie was

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passed through the cut into the bladder. Upon withdrawing the bougie, the sound, guided by the finger in the wound, glided easily into the bladder.

Ord.

Chloral hydrat, 3 j, at night.

May 2d.—No chill last night, but had one this morning. Gums sore from the mercury. Urine all passed through cut. Two blisters were applied to abdomen and an attempt made to give quinine endermically, but with little success.

May 3d.—But a very small quantity of urine being passed, and that highly albuminous and loaded with casts. Patient very weak. Nausea intense; vomiting almost incessant. There is tenderness and slight glandular swelling in the left inguinal region. Left side of hypogastrium tender. Iced champagne administered but is immediately vomited. A large poultice applied to hypogastrium. Only food taken is beef tea and milk in teaspoonful doses at short intervals.

Ord.

Hydrarg, sub-mur., ℈j dry on the tongue.

May 4th.—Urine again abundant. *Sp. gr.* 1.010. *Reac.* alkaline. *Albumen* ¼ of bulk. Nausea continued throughout the night with constant retching, both being present this morning.

Ord. (Acid hydrocyanic, dil Miij,) to be repeated every two hours if necessary. Mustard plaster to back of neck and three cups to kidneys. Less tenderness over hypogastrium. Scrotum inflamed.

Ord. Hydrarg. Sub. mur. grs. v, dry on tongue. Milk and lime water given in 3 ij, doses when desired. Much less nausea and retching to-day.

May 6th.—Complains of burning pain in stomach. Bowels moved twice up to 10 A. M. All the urine passes through cut. Ord.

Calomel, grs. v.
Quiniæ sulph. grs. ij.

May 7th.—Very little nausea and retching. Bowels moved freely, giving the characteristic stools of calomel. Gums very sore. Exhausted look has gone from face, and he appears much brighter. All urine still passes from the cut. Ord. Sol. potass. chlorat. ad saturandam to wash mouth every hour.

May 9th.—Patient feeling bright and well. Gums still sore. Appetite excellent. No nausea. Bowels regular. Urine passes in about equal quantities from cut and urethra. Poultice to abdomen discontinued.

May 11th.—Feeling so well that he wants to get up and sit in a chair. Still weak. No nausea. No pain. Appetite good. No instrument has been passed since the 1st ins't. until to-day, when a No. 10 (English) steel sound was introduced. Its point tended to emerge at the wound, but with guidance it passed easily into the bladder. Nos. 12, 14, 16, and 18, (E) steel sounds were then occasionally introduced and caused some little pain.

May 14th.—The urine all passes through the urethra, and gives no pain. Mouth still sore from mercury. Small abscess on right side of scrotum where he has been scratching it. Appetite good. Stronger

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and in excellent spirits. Urine less albuminous and free from granular casts. Ord

Infus. chammomile, 3 j. } t. i. d.
Acid sulph. aromat, Mv. }

May 15th.—Gums not so sore. Abscess in scrotum "broke" while patient was in privy, and discharged considerable pus. Feeling very well.

May 17th.—No. 18, (Eng.) steel sound passed into bladder easily and without pain. P't. put on ward diet. Soreness of gums almost gone. About two thirds of the urine passes through the penis.

May 22nd.—All urine passes through the penis. Doing very well. About the ward all day.

May 27th.—All urine per urethram. Allowed to go out on pass to-day. Doing well.

May 29th.—Urine all passes through penis. No. 18, (E.) sound passes into bladder without obstruction. Wound has closed entirely. Discharged cured.

NEWS ITEMS AND NOTES.

American Medical Association—Section of Practical Medicine, Materia Medica and Physiology, was called to order shortly after 3 o'clock by the Chairman, Dr. A. L. Loomis of New York. In the absence of the Secretary, Dr. J. Shoemaker, of Pennsylvania, was appointed Secretary *pro tem.* The first paper, read by Dr. Shoemaker, was a synopsis of his experience in the cause and cure of ringworm and its prevalence in public schools. Some interesting experiments with animals and children were related to show how the disease was exchangeable between them. The paper was discussed by Drs. Rich, Avery of Hartford, and Cutter of Coldwater, Mich., after which it was referred to the Committee on Publication.

In the absence of Dr. Beard the reading of his paper was postponed, and Dr. N. S. Davis of Chicago, read a paper upon the causes of pulmonary tuberculosis. He held that climatic influence was overrated, and that the real causes were a want of exercise, ill dressing and dampness. The paper was discussed by Drs. Dennison of Colorado, West, Caldwell of Baltimore, Scott of Cleveland, Bransell, of Masschusetts and Lester of Missouri. It was likewise referred to the Committee on Publication.

Dr. C. W. Glasgow, of St. Louis, presented an interesting specimen of fibrinous bronchitis.

Dr. Loomis spoke upon the subject of this disease, holding that the only cure was pure air. The Section moved to refer the subject back to Dr. Glasgow, that he might watch the further developments of the case and report at the next annual convention. The Section then adjourned.

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SECOND DAY.

The first paper read was one on yesterday's programme by Dr. George M. Beard, of New York, entitled : "Practical Points in the electrical treatment of Impotence and Spermatorrhea."

Dr. Beard's paper was discussed at some length by Dr. Caldwell, of Indiana, Rich of Philadelphia, Hibbard of Indiana, Palmer of Mich., Branson of Massachusetts, Shoemaker of Philadelphia, Woodbury of Philadelphia. It was referred to a sub-committee, consisting of Drs. Palmer, Hibbard and Branson.

Dr. J. J. Caldwell, of Baltimore, then proceeded to read a paper on "The Neuroses of the Pneumogastric and Sympathetic."

A paper on "The Metric System in Medicine," by Dr. Edward Wigglesworth, of Massachusetts, was read. The system, he stated, has been recommended for use throughout the United States by the State Medical Societies of both New York and Pennsylvania.

THIRD DAY.

Dr. Buckley not being present to read his paper upon the use of the solid rubber bandage in the treatment of eczema, that subject was discussed at some length by Dr. Martin of Boston.

Dr. Rochester presented a valuable pathological specimen in connection with his paper, which was discussed by Dr. Palmer of Chicago, Dr. Loomis of New York and Dr. Martin of Boston. The paper was referred to the Committee on Publication.

Dr. C. N. Palmer's paper on the use of ergot in the cure of goitre, was a warm defense of the properties of that medicine. Drs. Rochester, Blackwood, O'Hara, Hibbard and Hester, took part in discussing this paper, which was referred.

Dr. Davis of Chicago then started a long discussion on the address of Dr. Loomis before the General Session. The subject of the sanitarium was discussed from various standpoints, including the extremes of favorable and unfavorable opinions. It was carried on by Drs. Dennison, Rochester, Bronson, Davis, Bell and Shoemaker. The outcome of the discussion was a resolution that Dr. Dennison of Colorado be requested to study the subject of the climatic treatment of pulmonary phthisis as he found it in Colorado and report at the next annual meeting. The Section then adjourned *sine die*.

Section of Obstetrics and Diseases of Women and Children.—Dr. E. W. Jenks, of Detroit, Mich., in the chair. Dr. Reamy, who had been set down in the programme for the reading of a paper, being absent, the Section voted to give Dr. Theophilus Parvin, of Indiana, all the time necessary for reading the whole of his paper on Ovariotomy. The reading occupied three-fourths of an hour, but was listened to throughout with great interest. The relative value of the operations was then discussed by Drs. Miller of Chicago, Rive of Dayton, O., Dunster of Michigan, Storer of Newport, White of

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Buffalo, Sweet of Philadelphia, Lewis of Louisiana, and Jenks of Detroit. On motion of Dr. White, the Committee on Publication were specially requested to publish this paper. The Chairman gave notice that Dr. Reamy's paper would be read in to-day's session, and Dr. Engelman's would be omitted, in consequence of his absence. Dr. Smith of Philadelphia will also say a few words concerning some recent experiments of his. The Section then adjourned.

SECOND DAY.

The first paper read was by Dr. T. A. Reamy, of Ohio, on "Hour-glass Contraction of the Uterus," &c.

Dr. Reamy's paper was discussed by Dr. Miller of Chicago, Dr. Dunster of Michigan, Dr. Parvin of Indiana, Dr. Parker of Milesboro, Dr. Bontecue of Troy.

Dr. H. Storer, of Rhode Island, then read a paper on "The Frequently Gynecological Origin of Inherited Forms of Strumous Disease, and the consequent indications of treatment." The paper was referred to a committee.

THIRD DAY.

Dr. Levi P. Warren's paper on "Connection of the Hepatic Functions with Uterine Hyperæmias, Fluctions, Congestions and Inflammations," was read by Dr. Storer of Newport. It was a clear exposition of the dangers of treating specific diseases without due regard to general conditions.

Dr. Storer spoke strongly in advocacy of the principles put forth in the paper. The profession, he said, were in great danger of becoming too specific in the treatment of gynecological diseases, and he felt the time had come when a retrograde movement would be a benefit.

Dr. Bartlett, of Wisconsin, also endorsed the views of the paper.

Dr. Marcy spoke of the dangers which specialists were prone to run into in forgetting that there was anything to be watched, outside of their own territory.

The paper was referred to the Committee on Publication.

Dr. John C. Irish's paper on Dr. Burnham's Surgical Treatment of Uterine Fibroids, was read by Dr. Dunster. The subject was briefly discussed by Drs. Storer, Smith and Dunster.

Dr. E. Cutter of Boston, was unable to read his paper on the use of electrolysis for the same disease, on account of the unwillingness of a publisher to whom he had sent an abstract of the paper which the latter was about to print. He spoke simply upon the subject however. It was likewise discussed by Drs. Caldwell, Beard and Mussey.

Dr. George J. Engelman's paper on Battey's Operation for the Extirpation of the Ovaries was read by Dr. Dunster and briefly discussed by Drs. Treuholme and Rosebro.

The section then adjourned, *sine die*.

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Section on Surgery and Anatomy.—Was called to order by the Chairman, Dr. Henry H. Smith of Philadelphia. The Secretary, Dr. E, T. Early of Little Rock, Arkansas, performed the usual duties of that office. About two hundred physicians were present.

In accordance with the rules, a sub-committee, consisting of Drs. Post of New York, Watson of Jersey City, and Hyde of Cortland, N. Y., was appointed to examine papers read.

The Chairman stated that on account of the abundance of material on hand it would be necessary to adhere strictly to the rule that no paper should be read which would occupy more than twenty minutes. By special arrangement Dr. Howe, of Buffalo, presented a patient and gave a verbal account of a case of plastic surgery upon the eye, accompanied with photographs. Dr. C. C. F. Gay, of Buffalo, read an able paper on the "Excision of the Diaphysis of the Tibia." Dr. S. H. Weeks, of Portland, Maine, one of the surgeons to the Maine General Hospital, read a paper on "Septicæmia following Resection of Bones."

Dr. Waterhouse asked the difference between pyæmia and septicæmia.

Dr. Weeks replied that by pyæmia he understood the reception into the blood of pus or some of its elements. In septicæmia there is decomposing blood. There are other points of difference, as there are miteriotic abscess in pyæmia, but not wholly in septicæmia.

Dr. Keller had found that opium did not produce sleep except in doses dangerously large. Quinine could be given in large doses.

Dr. Woodward referred to the difference between septicæmia and pyæmia, and wished to know if the gentleman's statements were made on his own observation. He had seen blood poisoning without the existence of pus but had never seen pus in the blood, or found anybody who had. Dr. Henry A. Martin of Boston, read a paper on "Tracheotomy without Tubes." In the course of the paper he said he esteemed it the office of the physician not only to restore health but to mitigate pain, and not only when such mitigation may conduce to recovery, but when it may serve to make an easy passage from earth. Many physicians seemed to make it a kind of scruple and religion to stay with the patient after the disease is deplored, whereas, in his judgment, they ought to use their skill to assuage the pain and agonies of death. Dr. John T. Carpenter of Pottsville, Pa., read a paper on the "Identity of Hospital Gangrene with Diphtheria." He enumerated the following similarities between hospital gangrene and diphtheria, from which he claimed their identity :

1. In their causation—By an atmospheric contagion, becoming epidemic under suitable circumstances.

2. In the interchangeableness of their miasm—Either disease is capable of propagating the other.

3. In their pathological features—Exudation, ulcerations, mortifications, hemorrhage, esysipelas and general blood-poisoning.

4 In the double form of each disease—Simple, catarrhal or pulpy and malignant ulceration or phagedenic.

5. In the local infection as being preliminary to the general infection in such disease.

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6. In the parallel methods of cure and in the identical remedies used with success in both diseases.

7. In the similar modes of death and particularly the comparative frequency of heart clot in both diseases.

The Chairman read a letter of regret from Dr. D. M. Clay of Shreveport, Pa., and introduced Dr. Wychoff who presented Dr. Clay's paper on "Peri-typhlitic Abscess." On motion of Dr. Sayre of New York, the paper was read by title and referred to the committee.

Dr. Post, read a paper entitled "Plastic Surgery." Dr. E. M. Moore of Rochester, read an able paper on the "Prevention of Septicæmia in Surgery," which elicited considerable discussion.

The Section then adjourned.

SECOND DAY.

The attendance was very large. Dr. Moses Gunn, of Chicago, presided, and Dr. E. T. Easley, of Little Rock, Ark., occupied the Secretary's desk. The regular Chairman, Dr. Henry H. Smith, of Philadelphia, gave a continuation of his paper in the general session by a practical demonstration with preparations of certain points in the Pathology of Bones, especially Tubercles.

When Dr. H. H. Smith, of Philadelphia, had finished his practical demonstration in Section Three, which he did shortly before four o'clock, Dr. Julius F. Miner, took the floor and read a paper entitled: "The Extirpation of the Thyroid Gland," illustrating the same with several specimens, which were passed around upon plates. He was asked by Dr. Sayre, of New York, whether the vessels were ligated before or after division, and Dr. Miner replied that most of the blood vessels were ligated immediately after the division. Only one was generally ligated before division. Dr. Sayre then made some remarks upon the subject. He also discussed the subject demonstrated by Dr. Smith.

Dr. Miner was followed by Dr. B. A. Watson, of Jersey City, Surgeon to the Jersey City Charity and St. Francis Hospital, who presented a paper upon "Disease Germs, their Origin, Nature and Relation to Wounds."

On motion of Dr. Post, of New York, all papers read in the section were ordered to be referred to a Special Committee. Dr. Hodgen, of St. Louis, and Dr. Hutchinson, of Brooklyn, were appointed such Committee.

A paper was then read by Dr. Frederick Hyde, of Cortland, N. Y. on "The Process of Repair in Wounds, with and without Antiseptic treatment."

Dr. Robert Burns, of Philadelphia, followed with a treatise on "Conservative Surgery in Compound Fracturés."

Dr. Robert Battey, Rome, Ga., sent a letter regretting his inability to be present, but forwarded the paper which he was announced to read. It was on "The Permeability of the entire Alimentary Canal by Enemata, with some of its Surgical Applications." It was referred to the sub-Committee.

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The final paper of the afternoon was read by Dr. Post, of New York, on "The Excision of Phalanges of the Fingers and Toes."

THIRD DAY.

In the absence of the regular Chairman, the Secretary called the Section to order, and on motion of Dr. Gunn, Dr. Hodgen was called upon to preside.

Dr. Frank H. Hamilton, of New York, read his paper on "Ex-section of the Meta-tarsophalangeal articulation in valgus of the great toe," and the same was accompanied by photographs. Dr Hamilton particularly urged the value of the warm water treatment of wounds.

On motion the regular order was suspended to allow Dr. Sayre to exhibit to the Section a child that had been treated and cured of Pott's disease by the application of the plaster jacket, after the method peculiar to himself. The child had taken no medicine, and was free from any prominent deformity.

Dr. Gunn offered the following resolution.

Whereas: This section having expressed an opinion upon the results of long bones and

Whereas: In general convention a member has asked and been accorded the privilege of recording his protesting vote, Therefore,

Resolved: That this Section re-affirms its opinion that shortening, in cases of fractures of the long bones, is the rule in practice regardless of any of the means of treatment now in use.

The resolution was earnestly and warmly discussed by Doctors Keller and Sayre in the negative and by Dr. Frank Hamilton in the affirmative. The resolution was finally adopted, the only dissenting voices being Drs. Sayre and Keller, Dr. Sayre requesting that his protest against the opinion it expressed, be placed on record.

Proceeding with the regular order of business, Dr. John H. Packard, of Philadelphia, entertained the Section with an able paper on "Fractures of the wrist-joint," accompanied with specimens and illustrations.

The paper was discussed at some length by Dr. E. M. Moore, of Rochester, after which Dr. Theodore A. Mc'Graw, read a paper on the "Pathology, Diagnosis and Treatment of Cancer" which was referred without discussion.

Dr. Henry O. Harcy, of Cambridge, Mass., followed with a paper on "A New use of Carbolized Ligatures as Applied to Hernia."

On motion, papers by Dr. Andrews of Chicago, and Dr. Maddux, were read by title and referred to the appropriate committee.

The regular order of business having been disposed of, Dr. Moore, was afforded an opportunity to further discuss the paper read by Dr. Packard, and he proceeded to condemn the use of splints of all kinds for Colles fracture, claiming that it was dangerous and that adhesive plaster with the sling-bandage were the best appliances.

Dr. Moore was followed by Dr. Frank H. Hamilton, who, in speaking upon the subject under consideration gave an interesting account of his own practical experience. After further remarks by Dr. Hodgen the Section adjourned.

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Section of Medical Jurisprudence, Chemistry and Psychology had no papers, and did not organize. The Chairman, Dr. Walter Kempster, of Oshkosh, Wis., the Secretary, Dr. E. A. Hildett, of Wheeling, W. Va., and a few others, met and adjourned.

SECOND DAY.

In the absence of the regular Secretary his place was filled by Dr. Wm. Compton. The Chairman, Dr. Walter Kempster, of Oshkosh, Wis., read a paper on "General Pareisis of the Insane." It was discussed by Drs. Compton, Clarke, of Toronto, Russell, of Massachusetts, Ducke and Gray, of Utica. The paper was referred to the Sub-Committee in accordance with the rule of the Association.

THIRD DAY.

Dr. Theodore Ducke, special pathologist of the asylum for the insane at Utica, read a paper on "Microscopic examinations of the Nervous Centre," which proved of much value and interest to those who listened to it. The doctor exhibited several micro-photographs prepared by himself and Dr. Gray; and also specimen dissections mounted on glass for the microscope.

Dr. Knight of Connecticut, took occasion to speak of the beauty and perfection of the specimens exhibited, and on his motion a vote of thanks was tendered to Drs. Ducke and Gray for the instructive lesson they had given their professional brethren.

The paper was referred to the sub-committee for examination, after which the Section adjourned.

Section on State Medicine and Public Hygiene Dr. J. D. Cabell of the University of Virginia presided, and as soon as the Section was called to order, Dr. Henry J. Bowditch of Boston, read an interesting paper upon "Studies of Epidemic of Diphtheria which prevailed at Ferrisburg (adjacent to Vergennes) Vermont, 1877." The locality and course of the epidemic were traced out with great care and presented circumstantially. He presented the salient points of the epidemic and the paper was an exceedingly interesting one.

At the conclusion of his paper, Dr. Bowditch moved that his paper be referred to a committee of experts. Pending the vote on this motion, the paper was discussed by Dr. Jacobi and Dr. Bell of New York, Dr. Hollister of Chicago, Dr. Noyes of Detroit, Dr. Seguin of New York.

Dr. Toner moved as an amendment to the motion of Dr. Bowditch, that the paper be referred to a committee for publication. Dr. Jones of Toledo, in seconding the motion, took occasion to speak of contagion and infection, their causes, etc.

After further remarks by Dr. Jacobi, and Dr. Knight, and Dr. Isham of Connecticut, the vote was taken on the amendment of Dr. Toner, and it was carried.

Dr. E. Seguin of New York, next read the essay on the "Intervention of Physicians in Education."

Remarks commendatory, of Dr. Seguin's paper, and emphatically endorsing all that he said of the evil complained of were made by Dr.

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Bell of New York, Dr. Jones of Toledo, Dr. Frank Hamilton of New York, Dr. Noyes of Detroit, Dr. Storer of Rhode Island.

On motion Dr. Frank Hamilton was requested to present an outline of Dr. Seguin's paper to the general session of the Association, and give his own experience on the same subject.

SECOND DAY.

Some discussion occurred on Dr. Bowditch's paper, read yesterday, after which the following interesting papers on the subject of defective drainage, were submitted in the order given, and were referred to a committee, consisting of the Chairman and Secretary of the Section, with power. The first paper is by Dr. Thos. M. Stevens, of Indiana, on "Defective Drainage."

The subject of croup and diphtheria as contagious diseases was discussed by Professor Jacobi, of New York; Dr. Wilcox, of Hartford; Dr. Abbott, of Hamburgh; Dr. R. J. O'Sullivan, of New York; Dr. Reeves, of Wheeling, and others.

Dr. Bell, of New York, then offered the following resolution, which was adopted:

Resolved, That Dr. E. Seguin's paper on the "Intervention of Physicians in Education," be recommended for publication in the transactions, and that Drs. F. H. Hamilton, E. Seguin, R. J. O'Sullivan, of New York; Dr. D. B. Lincoln, of Boston; Dr. W. H. Van Bibber, of Baltimore, be appointed a committee to report to the Association at its next meeting upon the practical suggestions of the said paper.

Dr. J. S. Billings, U. S. A., of Washington, exhibited the plans of the John Hopkins Hospital, to be erected at Baltimore, showing improved plans of ventilation and drainage.

THIRD DAY.

Dr. J. D. Cabell, of Virginia, in the chair, and Dr. Bell, of New York, as Secretary.

The Chairman began the business of the afternoon by reading a letter from Dr. F. H. Hamilton, of New York, declining the invitation to prepare and present a paper at the next annual meeting of the Association, on the practical suggestions contained in Dr. Seguin's paper on the "Intervention of Physicians in Education," on account of time to devote to the preparation of the paper, and he did not expect to be present at the next annual meeting of the Association.

On motion of Dr. Bell, of New York, Dr. R. J. O'Sullivan, of New York, was appointed Chairman, and Dr. William Clendenin, of Cincinnati, Secretary, of a committee to present the report at the next annual meeting; declined by Dr. Hamilton.

On motion of Dr. Bell, of New York, the paper on State Medicine and Public Hygiene read by the President of the Section, Dr. Cabell, of Virginia, in the General Session, during the morning, was recommended to be printed in the transactions.

A criticism of the paper was then entered into by Dr. Bell, in which he made many excellent suggestions in regard to the sewerage

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in various parts of the country and the objectionable condition of most of the privy-vaults in villages and in fact nearly all of them outside of the larger towns and cities.

The President then read a lengthy but interesting paper on "The Bearings of Hygiene on Therapeutics," by Dr. J. R. Black of Newark, Ohio.

On motion of the Secretary, the paper was recommended for publication in the transactions.

Discussion of the paper was then invited, whereupon Dr. O'Sullivan of New York, made some very interesting remarks discussing the subject and treatment of diphtheria as on the day before. He called attention to the fact of the Catholic congregation in New York, one succeeding another until the air became charged with great impurities, actually becoming dangerous, and suggested a few minutes between the services for the æration of the church.

The section having completed its business, adjourned.

The Plague.—Advices from Bagdad to May 7th, state that it is rumored there that in Ispaham in Korsandjak, which lies to the south of the Urmia Sea, an epidemic disease, which resembles the plague, has broken out. According to Russian advices from Teheran, the plague has raged in Sondj Bulak (Persian Kurdistan) for three months, and has already caused 400 deaths. The epidemic of supposed malignant erysipelas in Hamada has turned out to be an epidemic of pustula maligna. The disease attacks principally the leather-workers of the town.

Wheelbarrows for the Sick.—The police commissioners of Dundee, Scotland, have supplied each police station with double-springed wheelbarrows, for the transportation of drunken and incapable persons. The new vehicles are said to be more convenient and easily managed than any other conveyances that has been tried for the same purpose.

Antiseptic Chambers.—Mr. W. Thompson F.R.S., of Manchester England, proposes the construction of a room, or series of rooms, for surgical purposes, that shall contain only air that has been so thoroughly filtered through layers of cotton-wool as to be entirely free from germ life. His experiments have satisfied him that such a plan is feasible.

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THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY.

A WEEKLY JOURNAL OF MEDICINE, SURGERY AND THE COLLATERAL SCIENCES.

EDITED BY

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LECTURES.

CLINICAL LECTURE ON CERTAIN FORMS OF SKIN DISEASE.

Delivered at Jefferson Medical College Hospital.

BY

FRANK F. MAURY, M.D.

Clinical Lecturer on Venereal and Cutaneous Diseases in Jefferson Medical School.

[Reported for THE HOSPITAL GAZETTE.]

I. MORPHŒA. II. ACNE ROSACEA. III. LUPUS VULGARIS.

Morphœa.—This little girl is three years and seven months old. Several months ago the mother tells me that the child hurt its head by falling and striking something. This is the resulting condition—the rare and interesting disease known as morphœa. You see the whitened appearance of all this right side of the scalp. It looks like a thin laid skin of bacon, or perhaps the best description would be to say that it looks as if it were inlaid. The surface is hard and hide-bound. The disease has only attacked the right side of the scalp. The whiteness begins just above the right ala of the nose and ends well down on the right side of the neck. The edges of this space are red and its temperature is a little lower than that of the adjacent parts, but it is not at all elevated. The spot is not without feeling, neither is it over-sensitive.

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This, as I have just said, is a disease of great rarity. I have never seen but one case like it before. The pathology and etiology of the condition are alike exceedingly obscure. Microscopic examination of the diseased structure has failed to clear up any of the obscurities which surround the disease. It seems to be very much like the striæ atrophicæ which are seen on the abdomen of a pregnant woman. Addison called this disease a form of keloid, but he was entirely mistaken as to its nature.

The prognosis of the local condition is highly unfavorable. The disease goes on indefinitely and usually terminates only with life. It has, however, no known deleterious effects upon the state of the general health. Thus considered it is entirely inert and harmless in every way. It is certainly very disfiguring to the face and scalp—an ugly scar carried with one through life.

Where the disease is acute, it may, like lupus vulgaris, cause more or less contraction and pulling down of the face. In this instance it is very passive. There is simply a shrinkage of the vessels and atrophy of the lymph channels. The subjective symptoms are very few in number.

The treatment is of course very simple, but very rarely productive of much change for the better. I will order two drops of Fowler's solution for the child after each meal. At the same time cod-liver oil should be administered in small, but continued doses. When the weather gets warmer the cod-liver oil had better be stopped.

Acne Rosacea.—This man has been under treatment in the out-door department for some time. I think he is gradually getting a little better. There appears to be nothing specific in this case.

Acne rosacea will attack any sex, or any individual at any time of life. The disease is usually located upon the face and is a cause of great disfigurement. There are three distinct stages of the disease. I. That of hyperæmia. This stage finds an excellent illustration in the condition known as "whiskey nose." The vessels are dilated. II. There is chronic enlargement of the vessels with the formation of papules which rupture with the discharge of pus. The dried pits form the III stage.

The causes of the disease are innumerable. Among them may be mentioned disorders of digestion, or of any part of the alimentary canal. The change of life in young girls at puberty, the presence of uterine diseases, or the use of cosmetics containing lead, zinc, or arsenic. Acne is a very common form of disease, only less so than eczema, which is by far the most common of all skin diseases.

The prognosis of acne is not good—the disease is extremely unlikely to get well fast. Its cure may require months, or even years. To effect a positive cure, the patient's whole method of life must be changed. A voyage to Europe is the best possible treatment when the patient has wealth enough to permit of it. In the majority of cases the condition is the result of a diseased state of the powers of assimilation. This being the case, the benefits to be derived from a foreign voyage can be readily estimated.

As concerns local treatment it is always well to apply some sort of

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alterative plaster, the best perhaps is that of mercury, the emplas. hydrarg. The alimentary tract should be kept thoroughly open by saline cathartics. The system needs a methodical course of drainage by salines. Among the best of such are Epsom and Glauber salts, Crab Orchard water, Hunyadi Janos, and German bitter waters.

In this case I shall order two teaspoonfuls of the Crab Orchard salt put in a tumblerful of water at bedtime and taken in the morning while the man is dressing. I think the common custom of swallowing down a tumblerful of the effervescent mineral water, or citrate of magnesia, a very bad one, particularly when the digestion is not good. Some of the contained gas is very likely to be detained in and distend the stomach and intestines. In addition to the mercury plaster as a local application, I shall order the following lotion for the face:

℞

Sulphuris sublim.,	ʒ ij.
Etheris,	ʒ iij.
Vini frumenti, q. s.	
Fiat lotio.	

Furthermore the man must not drink anything but a little red or white wine, and must be careful to refrain from fish and too much meat.

Lupus Vulgaris.—I have four cases illustrating this disease to show you.

Case I.—Here the disease assumes the character of an ectropion—a pulling out of the lower lid of the right eye. This, the woman says, began as a little wart to which she applied a plaster which she bought at the druggist's. I know nothing about it, but I think it very likely that the plaster contained some arsenic which assisted in forming the scar. These little scabs on the woman's right cheek show the existence of a tendency to epithelial degeneration. This epithelial degeneration is not the true cancroid. The sebaceous glands are clogged up. The capillary circulation thus interfered with, warty excrescences spring up and so lupus comes on.

Case II.—This old woman shows a scar one and a quarter inches long on her cheek. There are also two little scabs on her nose. This condition is very common in old age and also in the case of men who have shaved a great deal. It is very often caused by the application of cosmetics. It is, however, nothing more than a degeneration of the epithelium. Here I would advise the application of caustic potash, nitrate of silver, or sulphate of copper to the skin. In *case I*, perhaps it would be well to employ a lotion of corrosive sublimate (gr. j to f ʒ j) to the part. I have great faith in caustic potassa. It produces, I think, a radical change in the part.

Case III.—The condition of hyperæmia, which often occurs in acne rosacea also, is well illustrated in this case. The scar here differs very little from that seen in the other cases. There is one point to which I wish to call particular attention, and that is the method by which such sores as these should be wiped out. Do not rub the lint over the sore, but stretch the sides of the sore apart and press down the lint into the opening, allowing it to remain there long

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enough to soak up all the debris. I will order for this case an ointment containing 3 j of the ointment of the nitrate of mercury and 3 vij of cosmoline. This should be put on patent lint and then placed over the sore.

Case IV.—Does not differ much from those which you have just seen. An examination of the sores here reminds me of one other point. In touching these spots with caustic potassa be sure to sweep the caustic round the edges of the eroded surface. The edges of the sore are always blocked up by lymph and as the cicatrix travels from the periphery to the centre, the space round the edges must be clear from obstructions so that the blood vessels may find their way in, for until the vessels at the sides are in their normal condition nothing can be done towards the formation of cicatricial tissues. The treatment of *Case IV* must be the same as that for *Case III.*

CLINICAL REMARKS ON GONORRHŒA IN THE FEMALE.

Delivered at Bellevue Hospital, New York.

BY

JOHN T. DARBY, M. D.,

Professor of Surgery in the University Medical College, New York.

[Reported for The Hospital Gazette.]

Gentlemen: The woman I now show you is suffering from specific gonorrhœa. The local symptoms of which she complains are great heat and pain in the vulva, a profuse yellowish discharge, great burning and stinging pain in micturition and pain in the back and groin. She also has some general symptoms, such as fever, malaise, loss of appetite, etc. On examining the parts you observe that the nymphæ are very much inflamed, red and swollen, and bathed in a rather profuse ichorous discharge. The vagina is hot and exceedingly tender to the touch, and the urethra is in a condition similar to that of the neighboring parts.

We may often have a condition of non-specific vaginitis, which is similar in very many respects to the case I now show you, which, however, has a specific history, but if there be doubt concerning the origin of the disease, it is often a most difficult and many times impossible point to determine whether it is specific or non-specific, whether or not it has arisen from previous contact with a person suffering from gonorrhœa. There is one point that may aid you in the solution of the problem, but even when this condition is present you may still be in doubt, and that is the presence of inflammation in the urethra. In one case there is usually an intense burning in the urethral tract, while in non-specific vaginitis this is usually absent. I recollect one case now of a married lady who had acute vaginitis, with whom I am positive there had been no illicit connection, and her husband was perfectly free from disease, yet she had this same inflammation and burning in the urethra.

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We may have gonorrhœa attacking one part alone of the genital organs, either the urethra or the cul de sac back of the cervix. In cases where this is suspected a very careful examination should be made. The inflammation might exist only in Douglas, cul de sac and yet be sufficient to infect the male. In such cases we would be likely to have pain in the same situation as with a pelvic inflammation. When the inflammation is in the urethra, we have tenesmus, burning. and scalding. When the vulva is involved, as in this patient, the parts are sometimes immensely swollen, very red, bathed in discharge, and so tender, that the slightest touch causes severe pain. In well marked cases the temperature of the body is raised, and other general constitutional symptoms are quite prominent.

A few words as regards treatment. It is almost useless to attempt to cure the disease, when it exists in the female, by the administration of internal remedies, and it is almost as impossible when the disease exists in the male. The days of copaiba, cubebs, etc., are passed. The only proper treatment is a local one, and general treatment is only beneficial for the constitutional symptoms, or to make the urine less acrid and irritating to relieve the pain in micturition. Alkalies given by the mouth answer the latter indication.

In a severe case like the present, I should advise absolute rest, elevation of the hips, and the use of such local remedies as will assuage the pain and inflammation. The only medicines to be administered internally are to prevent the burning in the urethral tract. I discard entirely copaiba, turpentine, and the like as they do no good, while on the contrary they do harm by disturbing the digestion.

Use lotions applied to the part itself to act as a sedative, lead lotion is the best where there is a good deal of inflammation without very much suppuration. Direct the patient to sit over a vessel, and then by means of a fountain syringe inject the parts well. The continuous application of cold is sometimes very beneficial. If the bowels are constipated give a laxative to cause a free action, common Epsom salts or seidlitz powder will do very well. We do not wish to cause a diarrhœa, but simply to produce a few active movements so as to help remove the congestion.

The diet should be regulated so as not to be too stimulating. Rice and milk with stale bread may constitute the food until the fever has abated. If the fever runs high we may give tincture of aconite, or the tincture of gelseminum sempervirens. This latter is one of the best remedies I know of for the purpose in this disease. Understand, gentlemen, that I do not believe this agent has any specific influence on the disease, but it simply reduces the constitutional disturbance produced by a local cause.

I think it unnecessary to name over to you any more remedies, because their name is legion, but I simply wish to urge you against using any of the long list of nostrums for this purpose, or giving medicine by the mouth with the idea that you are in that way going to cure the disease. Use local measures entirely.

Sometimes the discharge is very profuse. In such a case, use warm water for the injections instead of cold as I directed you at

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first. Where suppuration is abundant the warm injections act better and, moreover, they are much more comfortable to the patient. In addition to the warm water injections, you may use astringents such as acetate of lead or tannic acid. Opium may be combined with these remedies as it tends to relieve the smarting they produce, and prevents pain by its direct action.

Another remedy of considerable efficacy is chlorate of potash. This may be used alone or in combination with the bromide of potash. A very good prescription is the following:

℞

Potas. chlorat.		
Potas. bromid,	aa	ʒ ss.
Aluminis		ʒ i.
Aquæ fervent,		O ij,

M.

This is one of the best remedies to alleviate the pain and stop the discharge.

I can not now go fully into the sequelæ of gonorrhœa, which sometimes lasts a considerable time. Dr. Noeggerath of this city, makes the astounding statement that when a man has once had gonorrhœa, it remains with him in a latent state, and that when he gets married he contaminates his wife with the disease. He asserts that various diseases of the pelvic organs, such as endometritis, perimetritis, etc., almost invariably follow. Whether this is so or not, I do not pretend to say. It is certainly a broad and astonishing statement, but the doctor is good authority, and we must attach some importance to what he says.

TRANSLATIONS.

ON THE USE OF CURARE IN THE TREATMENT OF EPILEPSY.

BY

DR. C. F. KUNZE.*

My experiments with Curare (Woorara) in 35 cases had very different results. Nine of the 35 cases made a perfect recovery. In most of them the disease had not been existing for a long time, say one, three or five years; in two of the successful cases the patients had been epileptic subjects for over 20 years. Among those who recovered there were some cases in which the disease had produced a well defined influence on the mental condition of the patients. Two of the cases which recovered were undoubtedly cases of inherited epilepsy, the history of these (brothers) is given below. I could obtain no good effect in old drinkers. My experience with Curare leads me to say that *Curare is one of the most efficient remedies for epilepsy.* A case of epilepsy should not be regarded as permanently

*Practise of Medicine, I, Page 204.

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cured, until a long time after the occurrence of the last attack. A short time ago I saw the return of the disease after an apparent recovery, extending over a period of 4 years.

I make a solution of Curare according to the following formula :

℞

Curare,	grs. vii. ss. (7½)
Aqua. dest.	m. 75.
Acid hydrochl. pur.	m. i.

hypodermically, and I inject about 8 drops every 5 or 6 days.

The addition of this small amount of hydrochloric acid makes the solution a clear one, and by this slight modification of my former formula I have avoided almost entirely the severe abscesses at the point of injection, of which I spoke in the 1st edition of this book.

History.—Edgar and Hugo Ufer are the sons of a subaltern officer in the Internal Revenue service at Botterfeld, Prussia. The father sustained a severe injury on the head, when, in 1846, during his service as a soldier he tried to stop the runaway of four horses attached to the carriage of the late King Frederick William IV. of Prussia. He was thrown down, dragged along for a distance and received a kick on the head by one of the four stallions. In consequence of the injuries brain symptoms developed, and the man suffered for over a year from convulsions and very severe headache. Five or six years later the injured man married and become the father of two sons, both of whom were attacked with epilepsy, one in his 18th and the other in his 13th year.

Hugo, the older of the two brothers, is now 25 years of age, and of sickly constitution. The first attack occurred July 6th, 1871, lasting for about one minute, another attack of somewhat longer duration took place the next day, being followed by three attacks on July 9th, occurring with intervals of from four to five hours. July 10th, again, three attacks; July 11th, a light, and three-quarter hour afterward a severe attack, lasting for about fifteen minutes. This last attack commenced with a disposition to weep, dizziness in the head, followed by a sudden unconsciousness. After the attack was over, there was a sensation of numbness over the entire body, the speech was heavy, the patient felt very tired and suffered from very severe headache. From July 11th to July 16th, generally, three attacks occurred daily. July 16th, 1871, the first injection of Curare was given. After the injection the patient felt slight symptoms of unconsciousness and dizziness, until towards night he felt perfectly well.

No more epileptic attacks occurred after the first injection. Once every week I gave the patient an injection. After three weeks the prodromatic symptoms, indicating the coming attack, became prominent, but disappeared soon after the prompt injection of Curare. After I had, during the period of six weeks, used about 3 grs. of Curare I omitted the injections, and until to-day (end of 1877) no more attacks have occurred.

Edgar, the younger brother, is now about 21 years of age, and is also not very strong. The first severe attack occurred March 21, 1870, the second in June, the third in November, 1870. The duration of the first attack was not quite an hour, with the second one the pa-

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tient was unconscious from 4 P. M. until midnight. The attacks came on without the outcry, and commenced with the sensation as if a stream of cold air was flowing from the mouth. Between the large attacks small ones of a few minutes duration always occurred. The first injection of Curare was given July 20th, 1871. From July 21st to July 25th there was some dizziness, and the patient felt as if an attack was coming on. This sensation, however, disappeared before long, and not a single attack occurred since that up to date (1877). The quantity of Curare used also amounted to 3 grs.; the injections were first given every week, afterwards every second week.

Hugo Noack, in Halle, Y. S., suffered since infancy from convulsions, which first commenced when he was only ½-year old and returned about once in four weeks. No other member of the family ever had epilepsy. The attacks always were complete. As to the cause of this disease, the mother of the patient states, that she once nursed the child shortly after a time of great anger. She says the attacks first made their appearance two hours later, and never disappeared since. The unfavorable influence of the disease on the patient's mental faculties, was well defined during the age of school-years, he did not learn well at all, and especially his memory, was gone almost altogether. The attacks occurred so frequently, that hardly a day or night passed by without convulsions. Noack came under my treatment in his 23rd year. After from six to eight injections the convulsions disappeared, and since then, for about eight years, no attack has occurred. Noack is now 31 years of age, married, and is the father of two children, none of whom have suffered from convulsions, up to this time. His mental faculties, and especially his memory have greatly improved since his recovery. Noack is employed now on one of the large railroads, and fulfills his duties satisfactorilly to his superiors.—PAUL H. KRETZSCHMAR, M.D.

PERISCOPE.

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BONY UNION OF FRACTURES OF THE NECK OF THE FEMUR WITHIN THE CAPSULE, WITH REPORTS OF CASES AND COMMENTS THEREON. BY WILLIAM SELDEN, M.D.— *Virginia Med. Monthly, Jan.* 1878, *p.* 289, *et seq.*

Dr. Selden reports four examples which have come under his own observation, of supposed cases of intra-capsular fracture united by bone.

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In case 1, the patient between 60 and 70 years of age fell upon the trochanter, and Dr. Selden diagnosticated intra-capsular fracture, but as it seems to us from insufficient data. She recovered and had a useful limb. Two years later she died, and the autopsy, made by Dr. Selden and two other surgeons, revealed a shortening of the neck of the femur to the extent that a finger could scarcely be laid between the head of the bone and the trochanter. "Upon sawing vertically through the head and neck of the femur, it was very manifest that fracture, a very oblique one, had commenced at the juncture of the head and neck, and that the upper fragment of the neck had penetrated the head for one inch and a quarter, the hard bony structure of the neck still remaining very obvious, and contrasting beautifully with the cancellated structure of the head, with which, gradually blending, it was firmly united". The gentlemen were not permitted to remove the specimen, and it was buried with the patient.

It was determined where the line of fracture "commenced," as Dr. Selden *thinks;* but if so little of the neck was left, it is not certain that the commencement of the line of fracture was not outside of the capsule, the portion of the neck attached to the head alone having been removed by absorption, as is usually the case, or the trochanteric fragment having been driven into the head until the reflected capsule was brought in contact with the head, or nearly so, and in that case, it is not always easy to say, two years later, whether the line of fracture was not partly within and partly without the capsule. One who reads the views of Malgaigne, Robert Smith, of Hamilton, and of Geo. H. Smith of Brooklyn, upon the pathology of these accidents, and upon the normal condition of the capsule, will see readily that the gentlemen might, in their necessarily brief, and imperfect examination, have made some mistake in this respect. Beside all this, it is well known now, that an appearance very similar to that presented in the spongy and cancellated tissue of the head and neck, is sometimes the result of purely post-traumatic changes, where no fracture had ever taken place.

On the whole, some degree of doubt rests upon the case, although one might admit that it *may* have been a genuine case of intra-capsular fracture united by bone. The *possibility* of which, Dr. Selden will excuse us for saying, Sir Astley Cooper never denied.

The 2nd case was not verified by an autopsy, and we should have no hesitation in view of the cause, symptoms and result, in pronouncing it a case of extra-capsular fracture, and it was followed by the usual results, shortening, etc.

The 3rd, case appears to have been—probably—an intra-capsular fracture: but there is no evidence that it ever united by bone. At the conclusion, the remarkable statement is made that the surgeon to whose care she was subsequently entrusted, after her recovery, reported "there is no apparent shortening of the limb." If Dr. S. means to say there is actually no shortening, the case stands alone in the history of these accidents.

Case 4th, may have been either intra-or extra-capsular, and there is

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no evidence to show that there is union by bone. The fact that the patient walks does not prove this. A fibrous union or even no union at all, in the case of an intracapsular fracture, permits most patients to walk as well as either of these patients were able to walk.

We think Dr. Selden attaches too much importance to ecchymosis as a diagnostic sign between intra and extra-capsular fractures. It is by no means uniformly present in extra-capsular fractures, nor is it always absent in intracapsular fractures, and it may be present where there is no fracture.

ISCHIATIC DISLOCATION REDUCED AFTER FIVE WEEKS. BY GEO. E. FENWICK, M.D., OF MONTREAL.—*Canada Med. and Surg. Jour., May.* 1878.

The patient, was a young man 21 years old. Under chloroform, on the 6th of April, 1878, Dr. Fenwick, twice failed by the method of "rotation," and in each case threw the head of the bone upon the foramen thyroideum. By reversing the movements the bone was carried again to the ischiatic notch. In the third attempt the "operator placed his hand firmly on the ascending ramus of the ischium, when the bone slipped with ease into the acetabulum."

SURGEON'S DUTY IN CASE OF MUTILATION OF THE HAND. BY M. VERNEUIL.—*Can. Jour. of Med. Science, June,* 1878.

Apropos of a little operation, which I am about to do on a young patient who entered our wards three months ago with a crushed hand, I must once more insist upon the course a surgeon ought to pursue in wounds of the hand. Whenever you shall have to treat a patient suffering from any crushing of the hand, adopt as an absolute rule, to excise nothing and to trim nothing with a knife. In those cases the surgeon ought only to think of warding off and controlling primary complications; but he should leave to nature the care of saving whatever she can save; she will preserve more than the surgeon, and will always waste less. We do not sufficiently clearly conceive how much of the lacerated, and on the first day condemned, tissues may resume their vitality and be repaired. Allow nature then to act. Wait. Later, after weeks, or even months, when cicatrization shall have occurred, then only should the surgeon interfere and trim the wound in such a way as to procure for the patient the fullest use of the limb.

RAPID LITHOTRITY WITH EVACUATION, BY H. J. BIGELOW. M. D. —*The Doctor. June* 1878.

Dr. Bigelow has proposed this name for a method of dealing with vesical calculus, first practised by him. Briefly, it is to complete the crushing at a single sitting, and at once to evacuate the detritus, small stones have been crushed at once several times, but Dr. Bigelow dealt thus with large ones, to enable him to do so he has modified the evacuating catheter, and it would appear that the method is very

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successful. He gave some account of it in the *Boston Med. and Surg. Journal* of Feb. 28, and March 7, and in the same periodical for May 2. Dr. T. R. Curtis supports him with details of three most successful cases. It would appear that the working of the lithotrite in skilled hands is really less dangerous than the presence of the fragments which are usually left behind. The recovery of the patients has hitherto been most rapid. In all, thirteen cases have been treated by this method with only one death, just the same mortality as attended Sir H. Thompson in his whole experience, one in thirteen. If the aim of the surgeon be to get rid of the stone in the shortest time with the least danger, and if future results prove as favorable, it would appear that Bigelow's operation may take the place of lithotomy, where many sittings for lithotrity seem to be contradicted.

OVARIOTOMY SUPERSEDED, BY M. TRIPIER.

A proposal has been brought before the Paris Academy of Sciences by M. Tripier, to establish a fistula between the cavity of an ovarian sac and the exterior. He has tried it in one case with success. The interior of the sac can in this way be washed out or treated with iodine injections or cauterized. He has used injections of iodized water daily. The galvano caustic is used to establish the fistula. This operation is less formidable than ovariotomy, and can be easily carried out, but, of course, is not devoid of danger, but it may be applicable in cases where gastrotomy is refused or inapplicable. With regard to injections, they should not be too strong. We may point out that death from poisoning by iodine has been recorded where the drug was injected.

This operation may be compared with electrolysis for ovarian dropsy.

NEWS ITEMS AND NOTES.

Poisonous Salicylic Acid.—A British Exchange thinks that an explanation of the ill-effects induced occasionally by salicylic acid probably lies in the difference between the natural acid and the product produced artificially. It is a fair assumption that the latter is not always devoid of carbolic acid, which would account for many of the distressing gastric and head symptoms that have been observed in patients who had been taking the drug for some time. A "note on salicylic acid," read by M. J. Williams, F. C. S., at a recent meeting of the London Pharmaceutical Society, states that his experiments have convinced him that the artificial acid, as supplied in commerce, is really made up of two bodies having very different properties.—*Med. & Surg. Rep.*

Appointments, Honors, Etc.,—Lister has been made an honorary member of the Royal Society of Physicians of Vienna. Charcot, J. Marion Sims, Hutchinson, Pacini, and Sommer, have been elected corresponding members of the same society.

—Mr. Edward Mettleship, has been elected Ophthalmic Surgeon

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to St. Thomas' Hospital, London, in place of Mr. Liebriech, who has resigned.

—Dr. Cohnheim, Professor of Pathological Anatomy in Breslau, has accepted an invitation to the same chair in the University of Leipsic, and is succeeded by Dr. Ponfick, Professor in Gottingen.

—We are highly gratified to learn that both prizes of the American Medical Association have been awarded to Dr. John A. Wyeth, of this city, for an essay on the surgical relations of the carotid, subclavian, and innominate arteries.

—Dr. Lewis A. Stimson has been appointed Professor of Pathological Anatomy in the University of New York.

—The Council and Faculty of the University of the City of New York have conferred the honorary degree of A.M., on Dr. Edward J. Bermingham, and that of LL. D., on Dr. S. Oakley Vanderpool.

—Brown-Sequard has been appointed to the chair of Physiology in France to succeed Claude Bernard.

Chrysophanic Acid.—Neumann, of Vienna, after extensive trials of chrysophanic acid (derived from goa powder) in the form of ointment, says it is an excellent remedy for herpes tonsurans pityriasis versicolor, and psoriasis vulgaris; even inveterate forms of psoriasis can be abolished by this means.

A Novel Milk Adulteration.—To the *Analyst* for April, Dr. J. Muter communicated the result of examination by him of a sample of milk to which his special attention had been directed, in consequence of the very low percentage of ash which his preliminary analysis showed. After numerous researches, he at last found that the foreign matter in the milk was glycerine, which is certainly a most ingenious addition, as a solution of that body in water of 12 per cent. strength has a specific gravity of 1.030; and he found, after several experiments, that 35 per cent. of such glycerine water might be added to milk without being detectable either by gravity or by the ordinary "solids not fat" process. Moreover, such an amount does not give any extraordinary sweetness easily detectable by the taste.

Dangerous Cosmetics,—In the *Analyst* for April, Mr. Charles Piesse says that he had submitted to him for analysis a small quantity of a white substance, in the condition of a magma, and he was informed in reference to it that it was used by an American lady as a face cosmetic. The lady, unable to purchase the preparation in London, desired to have some manufactured especially. The result of his examination showed that the substance consisted wholly of *calomel*, the wetness of the magma being due simply to water.

Ergot in Polyuria without Sugar.—Rendu (*La France Medicale,*) publishes a case of polyuria following a fall into the sea, cured by the administration of, for six days, 50 centigr. (7½ grs.) and afterwards one gramme of powdered ergot of rye. Valerian was found to be useless, and atropine, although it diminished the quantity of urine when given in doses of 1-66th gr. twice a day, produced unpleasant symptoms.

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